

PublicKnowledge

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Federal Way, WA 98023

September 13, 2016

Governor Kate Brown
Office of the Governor
900 Court Street NE, 160
Salem, OR 97301

Child Safety in Substitute Care Independent Review

Dear Governor Brown,

I am pleased to submit to you the Final Assessment & Review Report for the Child Safety in Substitute Care Independent Review.

Public Knowledge, LLC (PK) is honored to have been selected to conduct an independent review of child and youth safety in Oregon's child substitute care system. We conducted our review between February and September of 2016.

Over the past decade, a number of reports and reviews have revealed problems in Oregon's child substitute care system and suggested remedies. Little has been done to address the problems or implement the proposed solutions. The time to act is now. All participants in this independent review expressed a genuine desire to remedy the situation. There is broad awareness of the problems, and momentum in the state to fix the System.

We commend you for initiating this independent review and hope our findings and recommendations help move the state toward lasting solutions for Oregon children and youth. If you have any questions or require clarification, please contact me at (541) 206-4341.

Sincerely,

Melissa Davis
Project Manager

Cc: Clyde Saiki, Director
Oregon Department of Human Services
500 Summer Street NE
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Oregon Department of Human Services
Child Safety in Substitute Care
Independent Review

Deliverable 3.4
Final Assessment & Review Report

September 13, 2016

PublicKnowledge
ADVISING GOVERNMENT AGENCIES

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Executive Summary

At the request of Governor Kate Brown, Public Knowledge, LLC (PK) conducted an independent review of Oregon’s child substitute care system (System) over eight months (between February and September of 2016). Throughout this review, we focused on viewing the System from the perspective of children and youth living in substitute care. Although many aspects of the System merit deep examination, we focused on the two areas closest to the experience of children and youth in care: where they live (placements) and what happens when they experience abuse in care (response to abuse).

FINDINGS

The graphic below summarizes the nine major findings from this review.

Oregon Child Safety in Substitute Care Independent Review Findings	
Safe and Appropriate Placements	Safe and Swift Response to Abuse in Care
<p>More appropriate placements could prevent abuse of children and youth in substitute care.</p> <ul style="list-style-type: none"> • FINDING I - Space availability drives placement decisions, rather than the needs of children and youth. • FINDING II - Oregon’s placement capacity for children with high needs is shrinking. • FINDING III - Substitute care providers are not adequately trained or supported to safely care for children and youth with high needs placed with them. • FINDING IV - The urgency to find placements compromises certification and licensing standards. 	<p>A coordinated response to abuse in care could lead to earlier intervention and prevention of future abuse.</p> <ul style="list-style-type: none"> • FINDING V - Oregon’s response to allegations of abuse in care is confusing and involves too many uncoordinated elements. • FINDING VI - The CPS abuse in care reporting, screening, and investigation process is localized and may result in inconsistent responses to harm in care. • FINDING VII - The current process of abuse in care reporting is rated untrustworthy by youth and other reporters. • FINDING VIII - There is little to no follow-up on abuse in care investigations. • FINDING IX - Information that could mitigate safety concerns is not efficiently shared between entities.

The quantitative and qualitative data collected and analyzed during this review show that the state’s most acute problem is not having enough of the appropriate substitute care providers available at the moment when a child or youth needs to be placed in out of home care. Having the right provider for the right child or youth at the right time could reduce the risk of harm in care. Nonetheless, national data and standards tell us that even if Oregon were to invest in significantly increasing the number of high quality substitute care providers, there will always be a risk that something bad will happen in a placement. The state needs to have a transparent process for responding to abuse in care that puts the child first and is based on standardized protocols for screening and response.

Underlying both of these areas however, is the less tangible but even more critical reality that the culture of DHS and Oregon’s substitute care system needs to change. Over the past decade, a number of reports and reviews have revealed problems and suggested remedies. Yet little has been done to address the problems or implement those remedies.

THE PATH FORWARD

This review found little that has not already been discussed. We do not offer a “silver bullet” that will fix the problems in the System. What can make this review different from its predecessors is how the state, as a whole, responds to the recommendations suggested in the report.

The graphic below shows how implementation of our recommendations will lead to a future state that prioritizes child and youth safety in care: more appropriate placements could prevent abuse of children and youth in care, and a coordinated response to abuse in care could lead to earlier intervention and prevention of future abuse. In order to make needed changes, the culture of the System, including DHS, the legislature, the provider community, and advocates must prioritize the safety of children and youth who have been removed from their families and placed in the care of the state.

Oregon Child Safety in Substitute Care Independent Review Recommendations		Foundational Recommendations to Address Barriers
Safe and Appropriate Placements	Safe and Swift Response to Abuse in Care	
<p>More appropriate placements could prevent abuse of children and youth in substitute care.</p> <ul style="list-style-type: none"> • Increase provider rates for all provider types • Adopt an assessment tool to determine level of care and need, for use before placement decisions • Develop Oregon’s Continuum of Care and Availability • Build out alternatives to congregate care for children and youth with high needs 	<p>A coordinated response to abuse in care could lead to earlier intervention and prevention of future abuse.</p> <ul style="list-style-type: none"> • Redesign the Process of Responding to Allegations of Abuse in Substitute Care • Centralize hotline operations • Standardize screening protocols • Adopt a standard protocol for “closed at screening” 	<p>These recommendations are foundational to the system and any change efforts. If these areas are not addressed, the other recommendations will have little to no traction.</p> <ul style="list-style-type: none"> • Change the Culture of Oregon DHS • Focus the Whole DHS Agency and Child Welfare Workforce on Safety • Adopt Data Driven Decision Making Processes • Increase Staffing Resources for CPS and Other DHS Entities

1. Introduction

Oregon's children and youth experience more maltreatment in care than the national average (National AFCARS Data, 2013). Recent high profile lawsuits involving abuse of children and youth in substitute care have sparked multiple responses including new legislation. The state has paid out over \$31 million in settlements and awards in lawsuits where children and youth were abused by caregivers in foster homes and residential facilities in the last five years (excluding low dollar awards and sealed cases). The frontline caregivers - from caseworkers to foster parents and institutional staff - are suffering from overwork and turnover, inadequate training and support, and low morale; yet they are expected to shoulder much of the responsibility for ensuring children and youth are safe in care. Policymakers and leadership do not have good data on what is happening in the system, so solutions have been informed by single incidents and crisis response. From the perspective of children and youth in care, policy makers, legislators, the media, caregivers, DHS, and the public, the child substitute care system (System) is failing.

Over the past decade, a number of reports and reviews have revealed problems in the System and suggested remedies. Little has been done to address the problems or implement those remedies. Responses have been mostly focused on reframing the problem to deflect blame, comply with regulation, engage in required federal planning, or preserve the existing System.

Public Knowledge, LLC (PK) conducted an independent review of Oregon's child substitute care system over eight months (between February and September of 2016). Throughout this independent review, we viewed the System from the perspective of children and youth in care. Actions taken in response to this review, future breakdowns in the System, or directives from policymakers need to do the same: put the children and youth in care first and implement solutions focusing on their safety.

This independent review found little that has not already been discussed. We do not offer a "silver bullet" that will fix the problems in the System. What can make this review different from its predecessors is how the state, as a whole, responds to the report. The media, legislators, and department leaders need to focus on the work of changing the culture of the System and DHS. The culture must prioritize the safety of children and youth who have been removed from their families and placed in the care of the state.

The time to act is now. There is gathering realization in the state that the problems children and youth face in substitute care are systemic and need more than a quick fix. All participants in this independent review expressed a genuine desire to remedy the situation, and there is momentum in the state. Most importantly, the longer the state waits to implement impactful,

systemic change, the greater the likelihood that abuse of children and youth in care will continue.

This report documents findings, conclusions, and recommendations from our independent review of the System.

1.1. Scope of the Independent Review

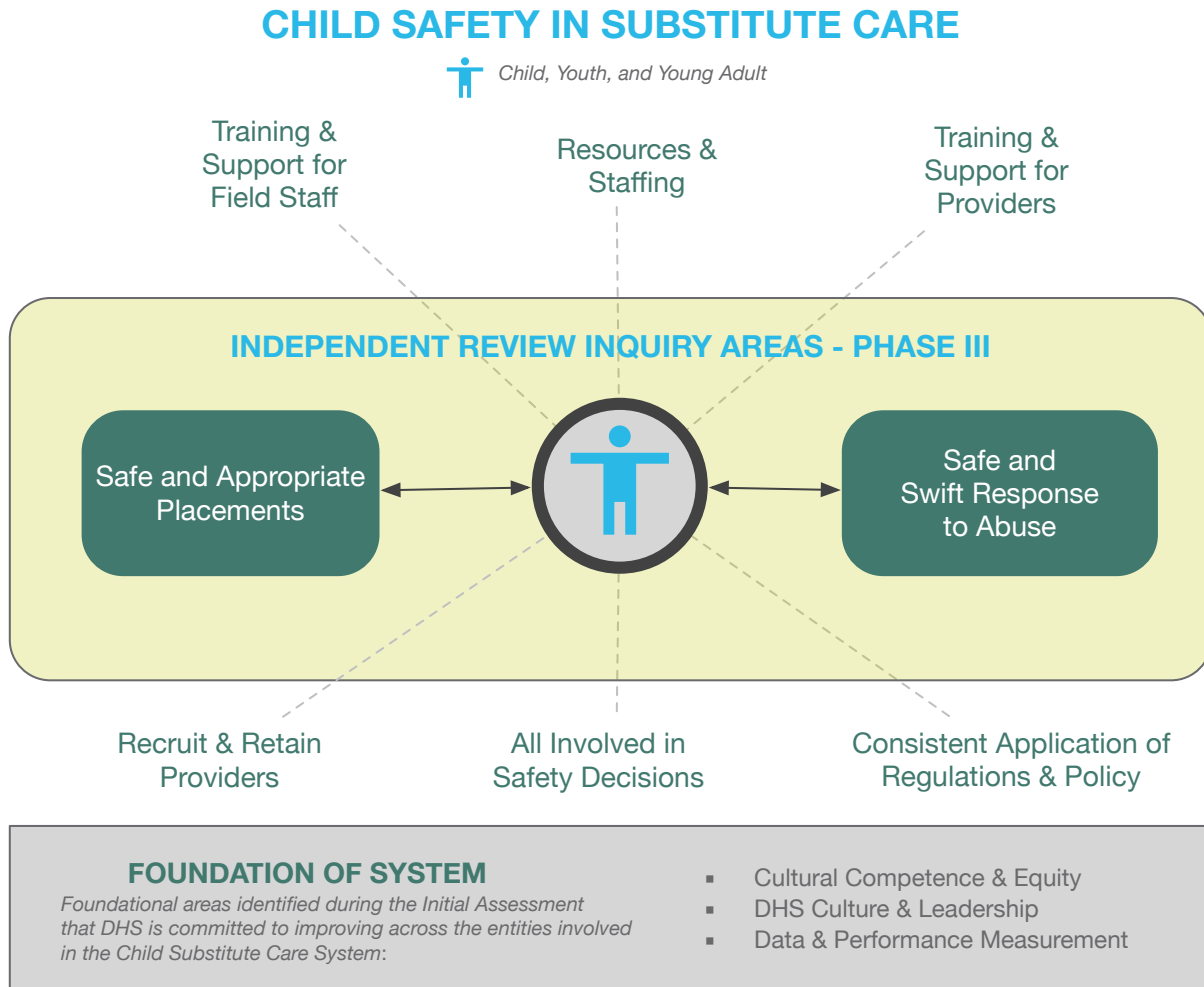
An independent review is an assessment of a policy, program, or system by an independent third party. In response to recent breakdowns in the System that led to abuses of children and youth in foster care, Governor Brown directed DHS to secure an independent, third-party contractor to provide DHS with recommendations to facilitate and support improvements necessary to ensure the care and safety of children served in the out of home care system.¹ PK was selected through a competitive procurement process to conduct the Child Safety in Substitute Care Independent Review.

The purpose of the independent review was to assess the operations, management practices, communication patterns, and accountability mechanisms related to providing 24/7 out-of-home care for children and youth who are under the custody of Oregon DHS (“substitute care”).

The methodology for the Child Safety in Substitute Care Independent Review was designed to continually narrow the scope as the review progressed through three phases: Project Initiation, Initial Assessment, and Comprehensive Review. By Phase III, we focused our inquiry on those areas of the System closest to the direct experience of children and youth living in substitute care: *where they live and what happens when they experience abuse in care*. Figure 1 shows the review’s focus areas.

¹ Oregon Department of Administrative Services. Opportunity Notice #DASPS-2534-15 for Department of Human Services Child Foster Care Service System. December 2015.

Figure 1: Phase III Scope



Each element of the System surrounding the child, youth, or young adult is integral to supporting their experience in substitute care. Those areas within the green shaded box were the areas of focus for PK during Phase III of this review. Areas outside the box are potential areas for future inquiry, and DHS and other stakeholders are currently addressing many of them. That work is captured in a separate work plan managed by DHS.

The independent review focused narrowly on the experience of children and youth currently in substitute care settings. Maintaining the boundaries of this scope has been a challenge throughout the project because substitute care is only one small part of a spectrum of child welfare services whose primary goal is to keep children and youth safe at home with their families² or move them to permanency quickly.

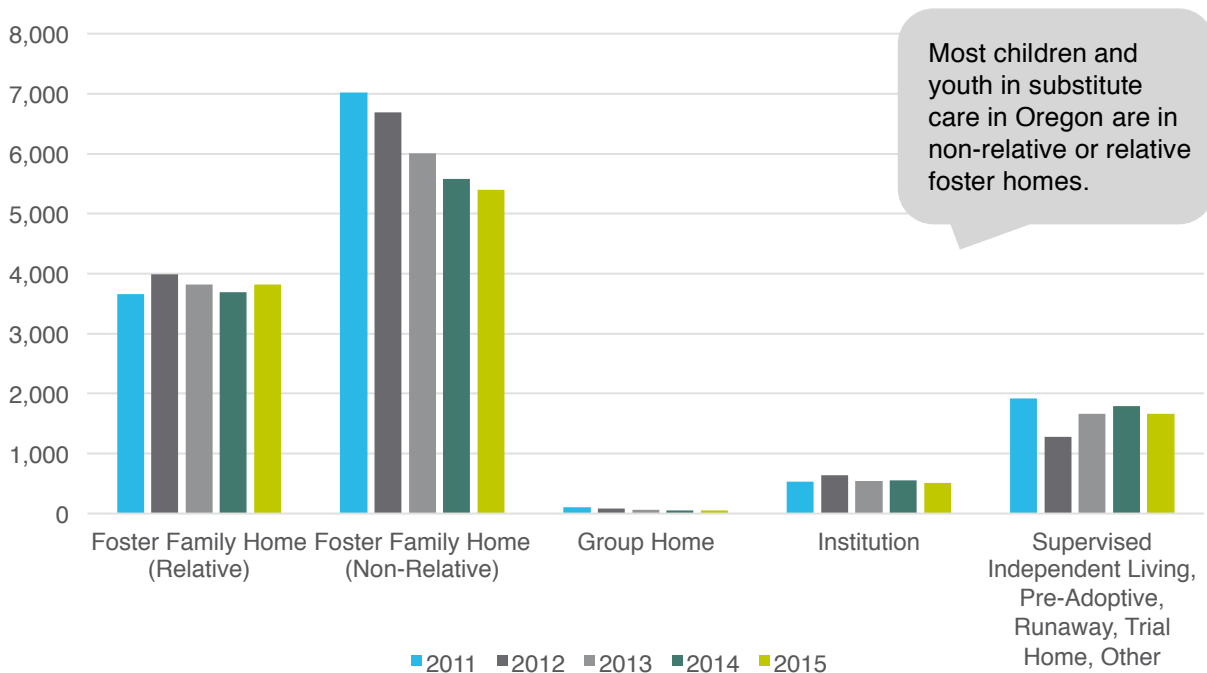
² Oregon Safety Model; Strengthening, Preserving, and Reunifying Families; and Oregon’s Differential Response model.

To be included in the scope of the independent review, an area of review had to meet all of the following criteria:

1. **Impact on child and youth safety in care.** Safety is considered from the child and youth perspective and through an equity lens to eliminate disproportionality and disparate treatment. Though permanency and well being are two other elements of the child welfare model, this review focused on child and youth safety in care.
2. **Children and youth who are already in substitute care.** Initial placement decisions, such as the original order taking the child or youth into state custody, were not included.

Figure 2 below shows the breakdown of children and youth by substitute care placement type over five years.

Figure 2: Count of Children in Foster Care (Total Served during Period) by Placement Type 2011-2015 (Public ROM)



3. **Children and youth who are in the custody of the Child Welfare Services Division of DHS.** This includes children and youth involved in the Developmentally Disabled system or the Juvenile Justice system, only if they are also under the custody of Child Welfare.

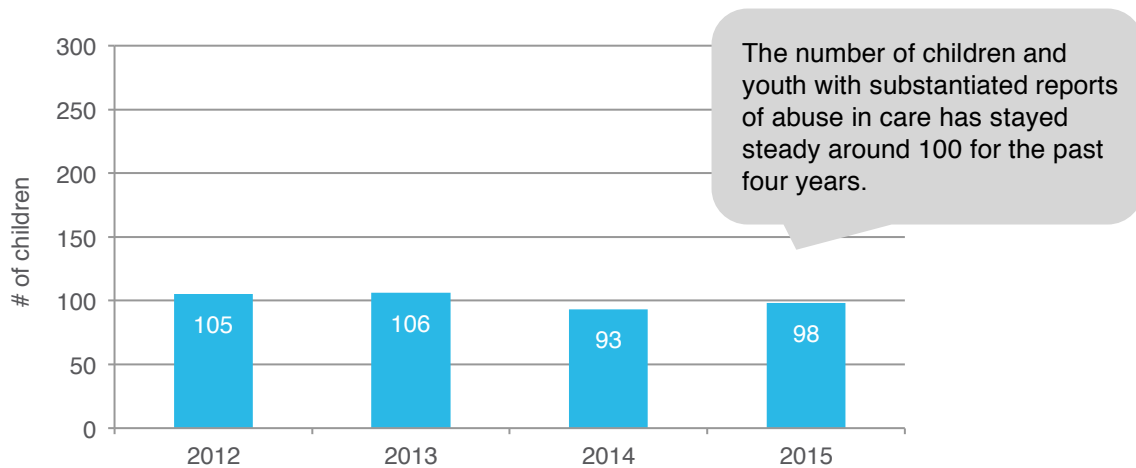
4. **Substitute care settings associated with substantiated harm in care.** We included all care settings for children and youth where harm in care has been substantiated in the last five years.³

1.2. Rates of Harm in Care by Placement Type

This section describes what DHS data shows about the placement types where abuse in care is occurring. Oregon currently has a disjointed data enterprise for tracking information about abuse of children and youth in substitute care. The data depends on multiple programs and systems that do not interface. While OR-KIDS, the DHS data system, has reporting capabilities, it does not have advanced reports set up on the data requested for this review. We could not verify the reliability of the data shown in this section, but include it here as part of the overall context regarding the placement types where children and youth may experience higher risks of abuse in care.

The number of individual children and youth in care with substantiated reports or allegations of abuse has been relatively stable, between 93 and 106 for the last four years. See Figure 3.

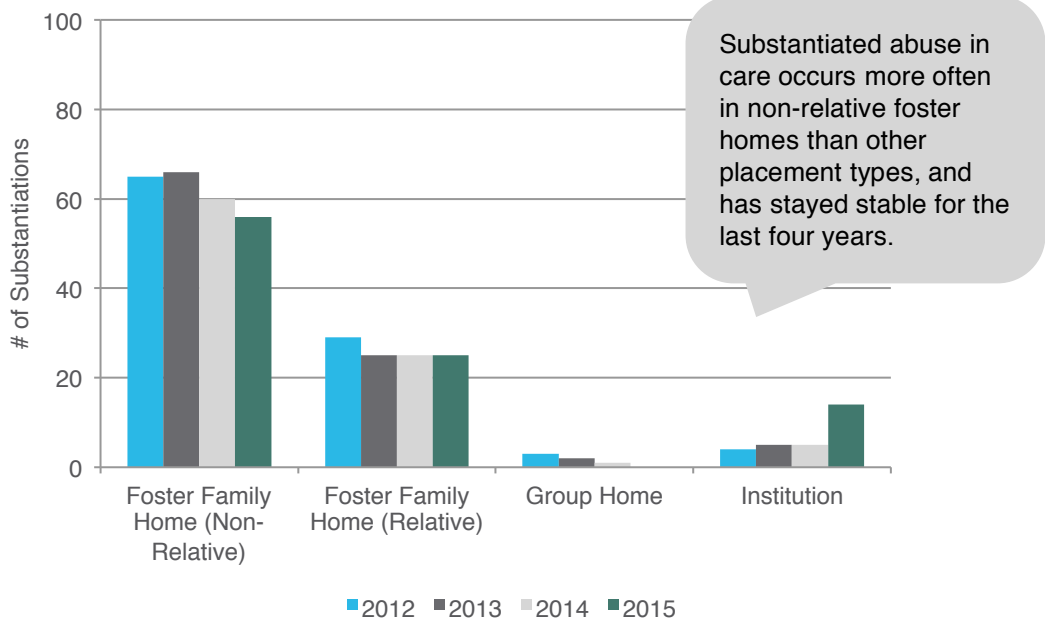
Figure 3: Count of Unique Children by Calendar Year with Substantiated Allegations of Abuse in Substitute Care (PK Data Request from DHS, 2016)



According to data from DHS, substantiated allegations of abuse in care occur more often in non-relative foster homes than other types of placements. Figure 4 shows the substantiated cases of abuse per year and by provider type.

³ Five years is the length of time since the 2011 Child and Family Services Review and corresponding Program Improvement Plan was implemented.

Figure 4: Substantiations by Calendar Year and by Provider Type (PK Data Request from DHS, 2016)

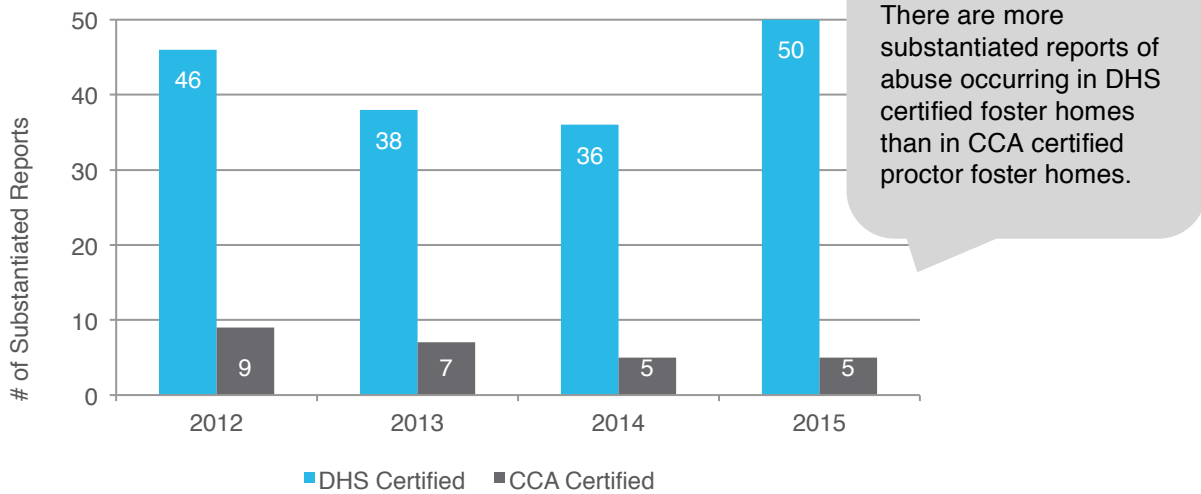


The independent review team reviewed all lawsuits filed against DHS in the last five years that ended in an award or settlement of \$50,000 or more. The findings of this review corroborate the data obtained from DHS. Of these 23 cases, two involved biological families, two involved a Child Caring Agency (CCA), and the remaining 19 involved DHS certified foster homes.

Several key informants who contributed to the Initial Assessment phase of the review reported that children and youth are abused in the CCA residential facilities (“institutions”⁴) more often than the foster homes certified by DHS (both institutional and proctor foster homes contracting with CCAs). This led to much of the focus and conversations with the review team to be on the topic of licensing and oversight of CCAs. Although abuse is occurring in these placement types at a higher rate compared to the total population of children and youth in the placement type, the data in Figure 4 above shows a significantly lower number of children or youth experiencing substantiated abuse in CCAs than in DHS foster homes. Additionally, data obtained from DHS shows that more children and youth in care are abused in a DHS certified foster home than a proctor foster home overseen by a CCA. Figure 5 shows the difference by substantiated reports of abuse. (Note that Figure 5 shows substantiated abuse by report, while Figure 4 shows substantiated abuse by child in care.)

⁴ The DHS data sets we analyzed use the term “institutions” to refer to residential treatment facilities run by CCAs. We use the term “institution” in this section as it relates to the data, but use “residential facility” throughout the report.

Figure 5: Substantiated Reports of Abuse in Foster Home Care by Certification Type (PK Data Request from DHS, 2016)

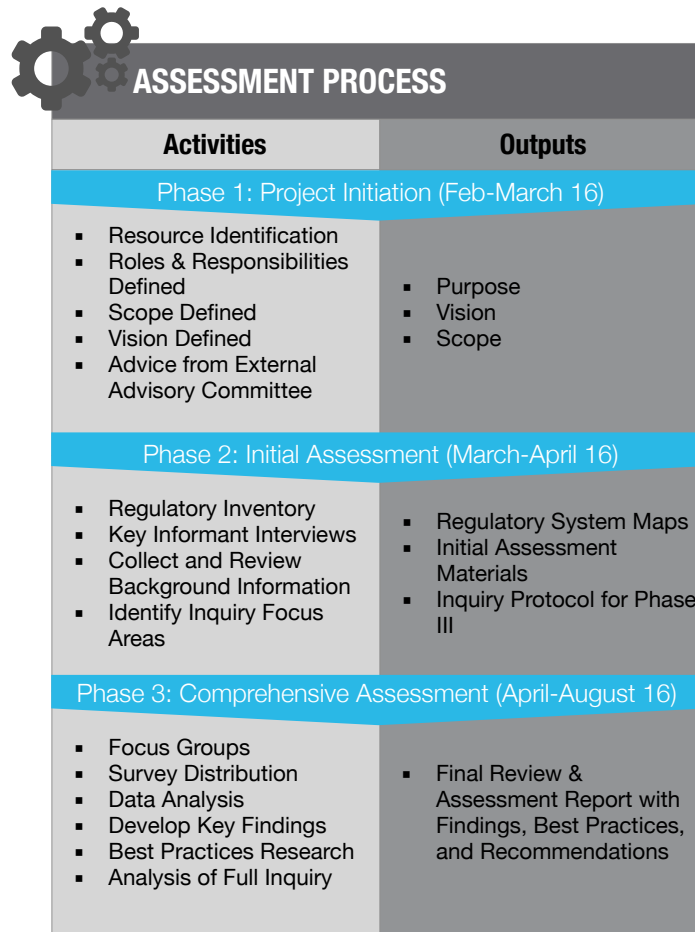


Qualitative data collected for this review shows that both DHS certified and CCA proctor foster parents need more skills and ongoing support to serve the children and youth with high needs in their care.

1.3. Methodology Overview

The methodology guiding this independent review was designed to obtain a broad view of the gaps and opportunities within the child substitute care system, and then narrow the focus to the most critical problems for deeper examination. The review progressed through three phases: Project Initiation, Initial Assessment, and Comprehensive Review. Figure 6 shows the high level approach model for this review.

Figure 6: Overall Approach Model



A detailed description of the methodology can be found in Section 5 Review Methodology.

1.4. Key Terms Used in this Report

Term	Definition
Behavioral Rehabilitation Services (BRS)	<p>“Behavioral Rehabilitation Services (BRS) is a program that provides services and placement related activities to the BRS client to address their debilitating psychosocial, emotional, and behavioral disorders in a community placement utilizing either a residential care model or therapeutic foster care model” (OAR 410-170-0020).</p> <p>Note: Child Caring Agencies (CCAs) can also be licensed to provide BRS services and many are, but they are not synonymous.</p>
Child Caring Agency (CCA)	<p>Any licensed agency, private school, or private organization (including institutions and group homes) providing day treatment for children with emotional disturbances; adoption placement services; residential care, including foster care or residential treatment for children; residential care in combination with academic education and therapeutic care, including but not limited to treatment for emotional, behavioral, or mental health disturbances; outdoor youth programs; and other similar services for children. A child caring agency does not include residential facilities or foster care homes certified or licensed by the DHS for children receiving developmental disability services (ORS 418.205). Child Caring Agencies are licensed by the</p>

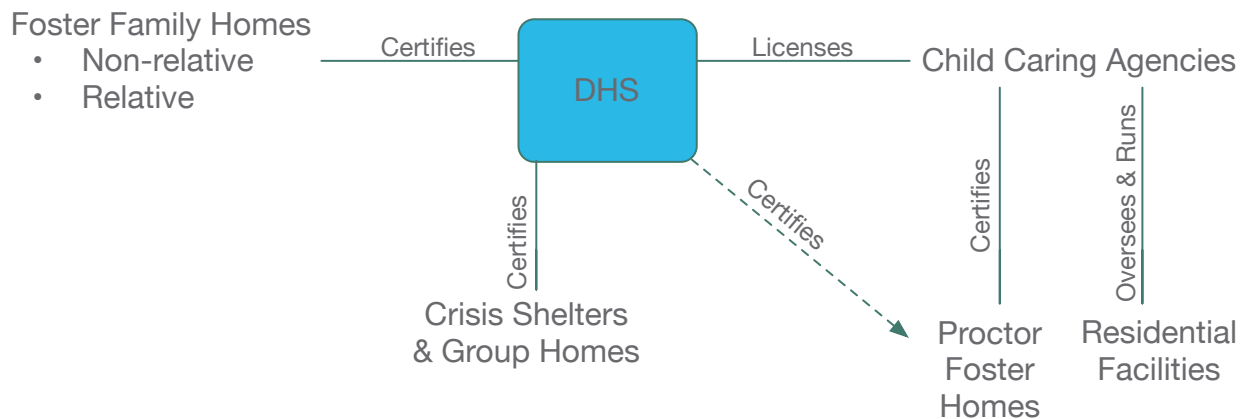
Term	Definition
	<p>Department of Human Services, Office of Licensing and Regulatory Oversight, and some contract with proctor foster homes (also known as professional foster homes).</p> <p>See Figure 7 for a graphical depiction of the contractual relationship of CCAs to DHS and other licensed or certified substitute care providers.</p>
Critical Incident	<p>CCAs are required to notify a DHS licensing coordinator if a critical event occurs: “A significant event occurring in the operation of a child-caring agency that is considered likely to cause complaints, generate concerns, or come to the attention of the media, law enforcement agencies, first responders, Child Protective Services, or other regulatory agencies” (OAR 413-215-0091).</p> <p>DHS Certified Foster Homes are required to notify the certifier or certifier’s supervisor if a critical event occurs, including: Any circumstance “that could reasonably affect the safety, health, or well being of a child or young adult in the home of the certified family...any change in the physical health, mental health, or medication of a member of the household...any suicidal ideation, significant behavior change, or significant injury or illness to a child or young adult” among other events that could affect the safety of a child or youth in care (OAR 413-200-0383).</p>
DHS Certified Foster Home	<p>A foster family home or relative foster home certified directly by DHS. A foster home maintained by a “certified family” caring for a child under the age of 21 years unattended by the child’s parent or guardian, providing the child with care, food, and lodging (ORS 418.625(1)(3), OAR 413-200-0260(8)).</p> <p>See Figure 7 for a graphical depiction of the relationship of certified foster homes to DHS and other licensed or certified substitute care providers.</p>
Foster Care	<p>A temporary living arrangement for children who need a safe place to live when their parents or guardians cannot safely take care of them. Types of foster care include relative foster care, in which a child is placed with a relative; child-specific foster care in which an individual or family becomes certified to care for a specific child, usually known to them in their community; and general foster care in which children are placed in with non-relatives. Foster care includes placement in a certified relative or foster family home or other child caring institution or facility (http://www.oregon.gov/DHS/Children/fostercare/Pages/index.aspx).</p>
High Needs	<p>High needs is defined as: children and youth with behavioral or physical health issues. In the context of this report, children and youth with high needs require “intensive” authorized levels of care, which dictates the amount of payments for care; challenging diagnoses, behaviors, and other characteristics where placements break down frequently and require new placements frequently.⁵</p>
Institution	<p>A licensed child care facility operated by a public or private agency and providing 24-hour care and/or treatment for children who require separation from their own homes and group living experience. The data included in this report uses “institution”, which refers both to the Oregon CCA definition, plus hospital-like settings and Psychiatric Residential Treatment Facilities (from federal definition and ROM). When the term residential is used in the data, it refers to just the DHS licensed residential programs through CCAs. See “Child Caring Agency.”</p>
Proctor Foster Home	<p>A foster home certified by a CCA (SB1515 Section 1(8)). A proctor foster home must meet minimum standards as established by rules adopted by DHS or the Oregon Youth Authority (OYA) (OAR 413-215-0313). Proctor foster homes also receive a pass through certification</p>

⁵ There is no universal definition of “high needs” pertaining to child welfare. This definition was adapted from: The Stephen Group. “Meeting the Needs of High Needs Children in the Texas Child Welfare System”. November 2015, p.11. www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf.

Term	Definition
	from DHS. These are also referred to as “professional foster homes” in the data and literature. See Figure 7 for a graphical depiction of the relationship of proctor foster homes to DHS and other licensed or certified substitute care providers.
Residential Facility	See definition for Institution above. Throughout this report we use the term “residential facility” or “residential program” unless we are referring to the data obtained from DHS, which primarily uses the term “institution.”
Substantiated Allegation of Abuse	A substantiated allegation means there is reasonable cause to believe that child abuse occurred (OAR 413-015-0115 (51)). Substantiated or “founded” allegations of abuse trigger notifications to identified parties certification review by the Department.
Substitute Care	The out-of-home placement of a child or young adult who is supervised by DHS or other agency, including placement in a certified relative or foster family home or other child caring institution or facility (ORS 419A.004).

Figure 7 below shows DHS’s licensing and certification responsibilities for substitute care providers. This graphic is provided as a reference because these terms are often confused. We use the terms in the graphic below throughout the report. The entities shown in Figure 7 are described in more detail in section 1.5 below.

Figure 7: DHS Licensed and Certified Substitute Care Providers



- DHS certifies foster family homes, both relative and non-relative. Certifiers housed in DHS district offices perform this function.
- DHS certifies crisis shelters and group homes.
- DHS, through the Office of Licensing and Regulatory Oversight (OLRO), licenses Child Caring Agencies (CCAs).

- Licensed CCAs oversee and run residential programs for children and youth with needs that cannot be met by general foster homes. CCAs also certify and oversee proctor foster homes. DHS provides a pass through certification for those proctor foster homes certified by CCAs.

1.5. Entities Referenced in this Report

Entity	Description ⁶
Child Welfare	Child Welfare is a continuum of services designed to ensure that children are safe at home and that families have the necessary support to care for their children successfully. In Oregon, Child Welfare includes Adoption services, Child Protective Services, Foster Care, and the Independent Living Program.
CPS	Child Protective Services. CPS responds to child abuse reports. CPS-trained caseworkers across the state listen to reports of abuse, assess the situations, and prepare safety plans to assist children and families.
CPS Hotlines	Child Protective Services Hotlines. There is a phone number anyone can call to report abuse of any child or adult to DHS. The hotlines are mostly decentralized, staffed by district offices.
DHS	Department of Human Services. DHS is Oregon’s principal agency for helping Oregonians achieve wellbeing and independence through opportunities that protect, empower, respect choice, and preserve dignity, especially for those who are least able to help themselves. Divisions include: Assistance, Children & Youth, Seniors & People with Disabilities, and other services.
OHA	Oregon Health Authority. OHA is the agency that oversees and administers Medicaid and other public health programs in Oregon such as the Oregon Health Plan, Healthy Kids, the Oregon State Hospital, and other programs.
OAAPI	Office of Adult Abuse Prevention and Investigations. OAAPI is part of DHS and is responsible for coordinating and conducting abuse investigations and providing protective services statewide to reports of neglect and abuse of vulnerable adults including: adults over the age of 65; adults with physical disabilities; adults with developmental disabilities; adults with mental illness; and children receiving residential treatment services.
OLRO	Office of Licensing and Regulatory Oversight. OLRO is part of DHS and is responsible for licensing or registering regulatory and corrective action functions for long term care facilities and agencies including children’s residential care agencies, foster care agencies, adoption agencies, assisted living facilities, and other such facilities and agencies.

⁶ These descriptions were taken from the DHS and OHA websites on September 04, 2016.

2. Findings and Conclusions

The report findings are categorized by the two areas of focus for the review: safe and appropriate placements and safe and swift response to abuse in care. Findings are summarized in Figure 8 below.

Figure 8: Findings Summary

Oregon Child Safety in Substitute Care Independent Review Findings	
Safe and Appropriate Placements	Safe and Swift Response to Abuse in Care
<p>More appropriate placements could prevent abuse of children and youth in foster care.</p> <ul style="list-style-type: none"> • FINDING I - Space availability drives placement decisions, rather than the needs of children and youth. • FINDING II - Oregon’s placement capacity for children with high needs is shrinking. • FINDING III - Substitute care providers are not adequately trained or supported to safely care for children and youth with high needs placed with them. • FINDING IV - The urgency to find placements compromises certification and licensing standards. 	<p>A coordinated response to abuse in care could lead to earlier intervention and prevention of future abuse.</p> <ul style="list-style-type: none"> • FINDING V - Oregon’s response to allegations of abuse in care is confusing and involves too many uncoordinated elements. • FINDING VI - The CPS abuse in care reporting, screening, and investigation process is localized and may result in inconsistent responses to harm in care. • FINDING VII - The current process of abuse in care reporting is rated untrustworthy by youth and other reporters. • FINDING VIII - There is little to no follow-up on abuse in care investigations. • FINDING IX - Information that could mitigate safety concerns is not efficiently shared between entities.

2.1. Safe and Appropriate Placements: More Appropriate Placements Could Prevent Abuse of Children and Youth in Substitute Care

Abuse in care often stems from placing children and youth with caregivers who are over capacity, not qualified to meet their needs, or not supported. Data collected for this review shows that inappropriate placements may result from a scarcity of placement options, fewer placement options for high needs youth, and inadequate training or support for foster parents caring for foster children and youth with high needs.

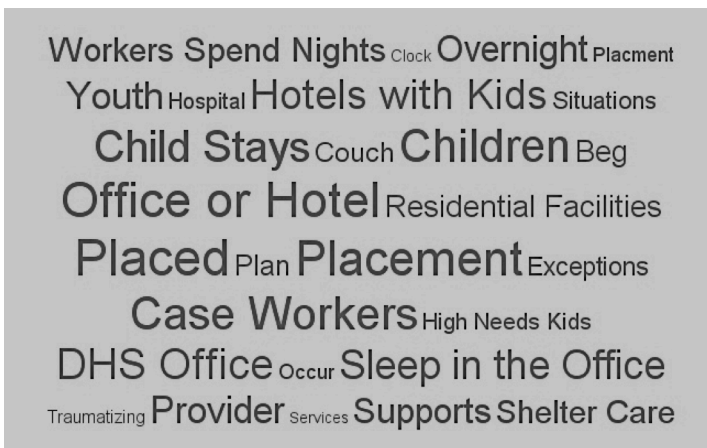
“The Department at times struggles with appropriate placement matching due to the complexities of children’s needs and the limited number of providers. Although there may be certified homes, there are times when homes are not available for children with complex behavioral or health care needs”
 - Oregon Child and Family Services Plan, 2015, p. 50

2.1.1. Finding I - Space availability drives placement decisions, rather than the needs of children and youth.

Appropriate placements for children and youth in substitute care are not consistently available, sometimes forcing DHS staff to place them with providers who cannot meet their needs. A CFSR Statewide Assessment identified lack of resources as a driving factor in placement decisions, stating that, “Waiting lists for needed services often result in children getting served by the first available resource rather than the most appropriate resource” (CFSR Statewide Assessment, 2007, p. 128).

DIFFICULTY FINDING PLACEMENTS

Figure 9: Word Cloud from open-ended responses, Question: What happens if there is no available foster home with proper training to take in a high needs child or youth? (Caseworker & Supervisor Survey Results)



Focus group and survey results highlight the difficulty caseworkers have finding appropriate placements for children and youth. Figure 9 shows the most frequently used words used in response to the open ended question “what happens when there is no available foster home with proper training to take in a high needs child or youth?” During the timeframe of this review, news articles reported issues of space availability: “DHS

officials told FOX 12 that on average, six foster children a week state-wide spend at least one night in a hotel or child welfare office” (“Crisis’ in Oregon Foster Care System,” August 8, 2016). DHS staff told reviewers that although the media is currently highlighting this problem, caseworkers have been spending nights in DHS offices with unplaced children and youth, lodging them in hotel rooms, and begging providers to take them for years. A 2011 Sensitive Review Committee Report found that, “Planful foster care placements to ensure stability often does not occur, primarily because of limited capacity and limited access to specialized training for foster parents and relative caregivers” (Sensitive Review Committee Report, 2011, p. 5).

ASSESSMENT TOOLS

Appropriate placements are dependent on a complete assessment of a child and family’s needs and strengths, as well as timely family finding for appropriate relative placement options. Oregon does not use an assessment tool prior to placement to determine the needs of children and youth, and therefore cannot proactively match children or youth to the qualifications of caregivers. Nor does the state use an assessment tool to identify the level of care provided by the pool of caregivers. Therefore, no data is available to show need and availability for each placement level or type.

The Department recognizes the importance and role of assessment as evidenced throughout Oregon’s child welfare rules and regulations,⁷ the DHS Child Welfare Manual, and articulated in the 2007 Children’s Wrap Around Initiative, but the consistent application of policies and procedures is not evident. It appears that due to the scarcity of placements, DHS is not able to adequately put this policy into practice.

Oregon uses the Child and Adolescent Needs and Strengths (CANS) Assessment once a child or youth is placed in substitute care, but only to determine payment rates and service plans. There is no level of care assessment conducted prior to placement.

“Level of care is not used to help find the right placement. Only after the child is placed is the personal care assessment done. And usually this is about a month after being placed.”

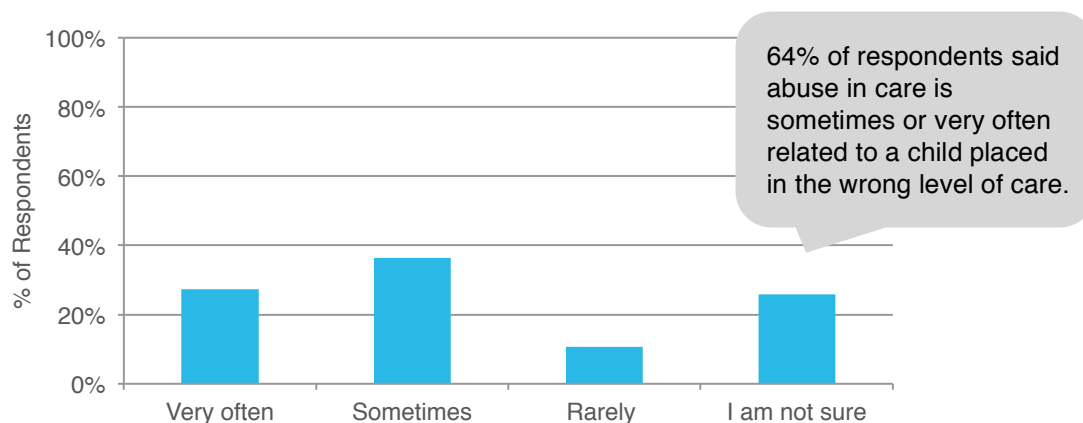
- Foster Parent Survey Respondent

DHS foster home certifiers reported in a focus group that DHS is not currently capable of matching children’s needs with qualified foster home placements to meet those needs, due to limited availability of qualified foster home placements. According to review participants, this can lead to higher risk of abuse in care.

⁷ See Oregon Administrative Rules (OAR) 413-070-0600 and 413-070-0625.

- 67% of foster parents surveyed said the needs of foster children and youth are not matched to providers' qualifications.
- Over 60% of attorneys and judges surveyed note that abuse in foster care is sometimes or very often related to a child or youth being placed in the wrong level of care for their needs. See Figure 10.

Figure 10: When abuse occurs in foster care, how often is the abuse related to a child or youth being placed in the wrong level of care for their needs? (Attorney and Juvenile Judge Survey Results)



2.1.2. Finding II - Oregon’s placement capacity for children and youth with high needs is shrinking.

High needs is defined as: children and youth with behavioral or physical health issues. In the context of this report, children and youth with high needs require “intensive” authorized levels of care, which dictates the amount of payments for care; challenging diagnoses, behaviors, and other characteristics where placements break down frequently and require new placements frequently.

According to the 2016 CFSR Statewide Assessment Instrument, “While there is no way to capture the number of children in regular foster care who should be in a higher level of treatment care, stakeholder reports indicate that across the state children who meet criteria for BRS placement are living within the regular foster care system” (CFSR Statewide Assessment Instrument, 2016, p. 23).

PLACEMENT CAPACITY

Oregon’s placement capacity, especially for children and youth with high needs is inadequate to meet the demand. Multiple recent reports and reviews have found this to be the case:

- “[DHS] Child Welfare may not be adequately assessing the capacity of programs to provide services for high-needs children and the appropriateness of those services” (CIRT Review 2012-2014, p. 2).
- “Children with multiple handicapping conditions are difficult to place and provide with comprehensive services” (CFSR Statewide Assessment, 2007, p. 128).

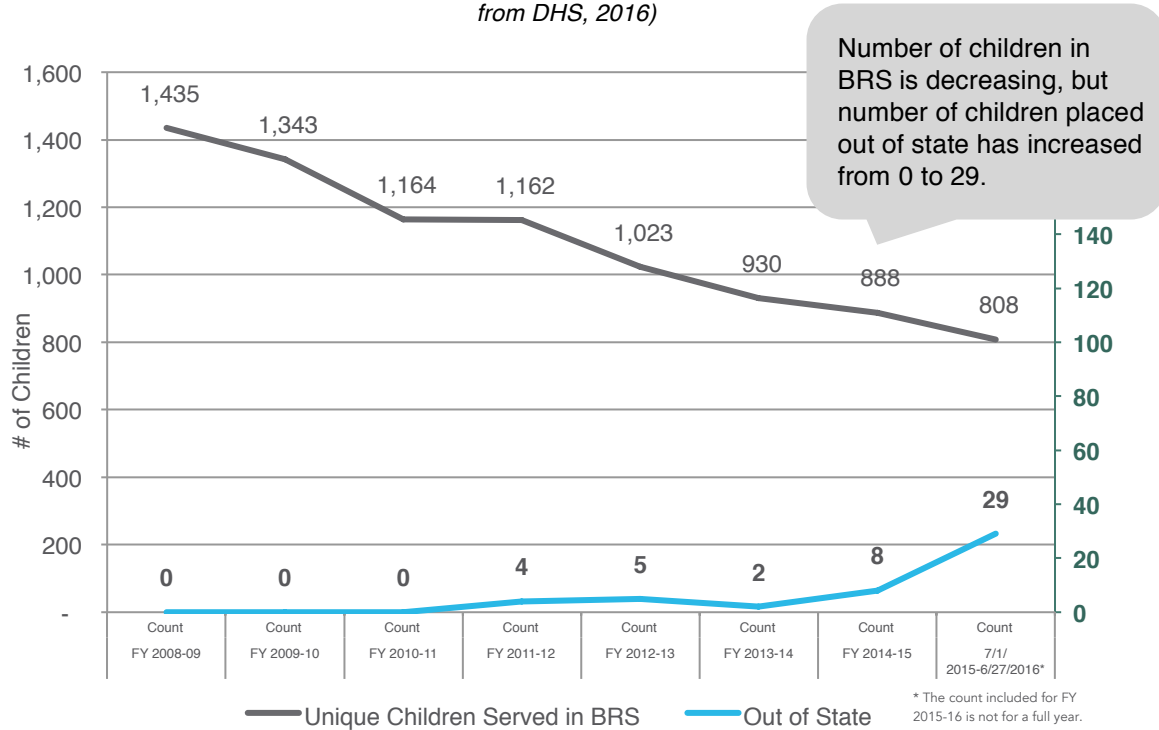
Residential bed capacity for children and youth with high needs appears to be steadily declining, decreasing 12% just over the past year (PK Data Request from DHS, 2016).⁸ There are limited step down placement options for those high needs youth who truly need intensive out of home care. It appears that Oregon has not historically focused on building out intensive therapeutic foster care (TFC) services for those children and youth in need of residential services. Instead, these children and youth are put in foster homes not trained or equipped to handle their needs.

88% of attorneys and judges surveyed see placements that exceed providers’ capacity, and 65% have seen caregivers not having sufficient training to care for the needs of foster children and youth in their care.

The need for intensive placement settings (e.g., residential treatment or therapeutic foster care) remains higher than Oregon can meet with in-state resources. While the number of children and youth in BRS placements is decreasing, the number placed in an out-of-state psychiatric residential treatment facility is increasing. In 2015, 3.6% of children served in BRS placements were placed out of state, up from 0.3% in 2012, and none in the years before that. See Figure 11. Sending children and youth out of state for services removes them from their community and support system and is expensive for the state.

⁸ Some review participants believe that this decrease may be a positive sign that problem providers are leaving the System.

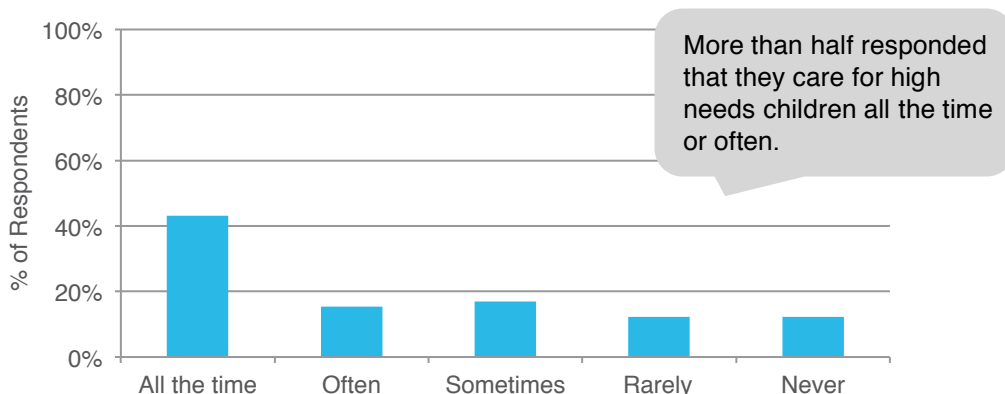
Figure 11: Number of Children in BRS Placements and Number of Children Placed Out of State (PK Data Request from DHS, 2016)



While survey respondents and focus group participants reported “high” or “very high” demand for all levels of substitute care in Oregon, they rated the need for BRS placements the highest (this includes foster parents, DHS caseworkers and supervisors, staff of CCAs, Citizen Review Board (CRB) staff, CASAs, and OLRO licensing coordinators). Participants CRB focus group reported that many TFC and group homes in Oregon have closed in recent years, leaving children and youth with significant needs without options because, “they can’t be placed in normal homes ...there isn’t a place for them” (CRB Focus Group Results).

More than half of the foster parents surveyed reported that they care for children and youth with high needs all the time or often. See Figure 12.

Figure 12: "How frequently do you care for high needs children or youth? (Foster Parents Survey Results)"

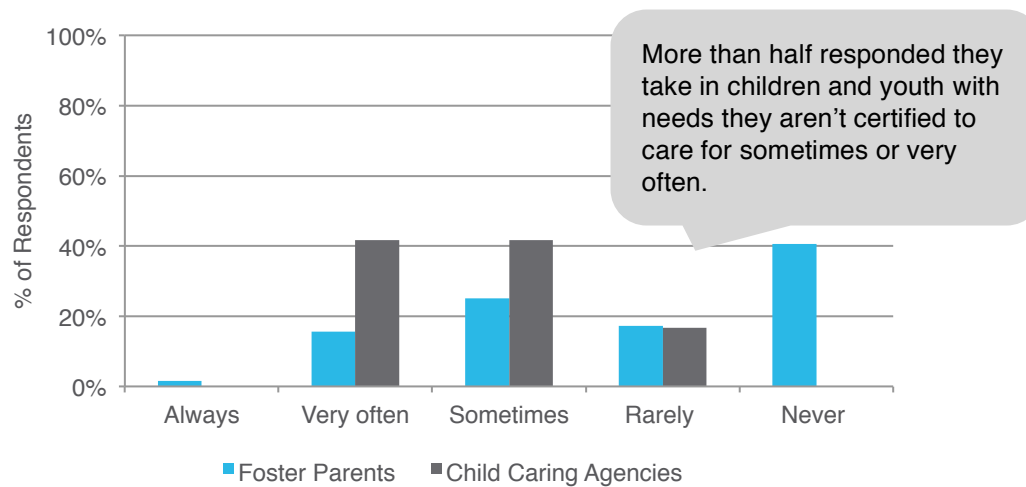


Scarcity of placements for children and youth with high needs can force inappropriate placements leading to negative outcomes, including safety issues. Participants in a CRB focus group reported that when a child or youth with severe behavioral issues who should be placed in a residential facility is placed with an untrained family, it puts everyone at risk. Problems also arise when children or youth with complex needs are placed in institutional settings that cannot meet their therapeutic needs. According to a recent report from a Juvenile Justice Mental Health Task Force: "A lack of psychiatric services, residential beds, and crisis placements has led to youth being held in less than ideal settings, such as detention or in hospitals. These settings are ill equipped to help youth with significant needs, many of whom have suffered abuse, neglect, and trauma. These settings can exacerbate underlying trauma, are expensive, and are not conducive to producing positive outcomes" (Juvenile Justice Mental Health Task Force Report and Recommendations, 2016, p. 1).

2.1.3. Finding III - Substitute care providers are not adequately trained or supported to safely care for children and youth with high needs placed with them.

DHS is placing children and youth with high needs with caregivers who do not have the skills or training to care for them. Both DHS certified foster parents and representatives of licensed CCAs report in surveys being asked to care for children and youth whom they do not have the right skills or training to serve. See Figure 13.

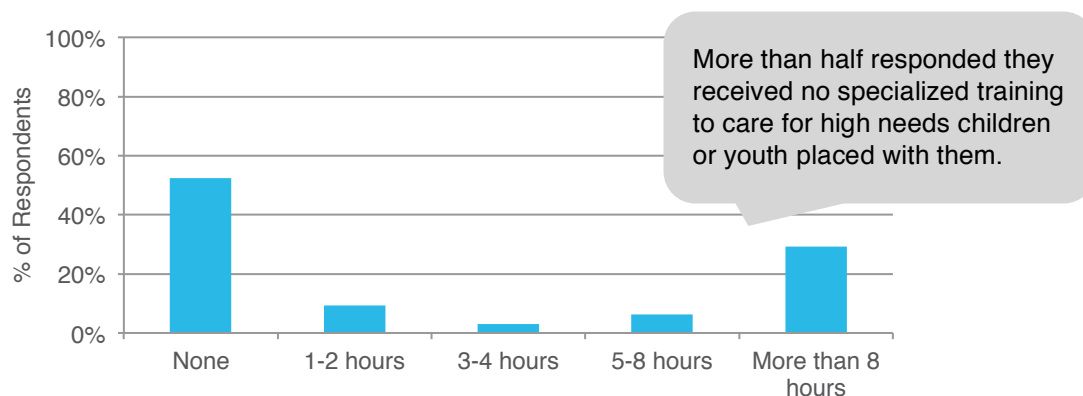
Figure 13: How often has DHS requested you take in children or youth with needs you are not certified to care for? (Foster Parents & CCA Survey Results)



Foster parent focus group participants indicated almost unanimously that they do not have the training to safely care for the needs of children and youth being placed in their homes. Foster parents who work with CCA’s reported more and better training than the DHS foster parents in focus groups. Survey results from of both CCAs and DHS certified foster parents mirror the focus group results:

- 50% of child caring agencies surveyed report the children and youth placed in their care need a higher level of care than they are able to provide.
- Over 50% of foster parents surveyed report frequently caring for children or youth with high needs. In addition, over 50% of respondents report receiving no specialized training to care for children and youth with high needs. Based on survey comments, the delivery of specialized training also appears to be inconsistent across the state. Some respondents indicated that they must self-educate, and others indicated that their county offices provide regular opportunities for training. See Figure 14.

Figure 14: Did you receive specialized training to care for high needs children or youth placed with you? (Foster Parents Survey Results)



Participants in the review reported that foster parents typically get the support, information, and training they need to care for high needs kids from places outside of DHS. Some examples include Casey Family Programs, local mental health agencies, or the Internet.

The most recent CFSR Self Assessment corroborates the data collected from this review in its findings for why foster children and youth experience multiple moves within the System: “foster parents who are not equipped to meet the special needs of the child, may lack available child care, may be filled beyond capacity, or may lack local resources to meet the level of support needed for the child” (CFSR Statewide Assessment Instrument, 2016, p. 23).

TRAUMA INFORMED CARE

Review participants and substitute care system stakeholders agree that the state needs to infuse trauma informed care throughout the System. Focus group participants noted deficiencies in the trauma informed training and support provided to foster parents, staff of licensed CCAs, and the DHS staff who support them:

- Foster parents report that there is not enough trauma informed training, transitional therapy, or preparation for issues around separation and loss – on both the part of the children and youth they serve, and themselves.
- Foster parents say that when they call a caseworker for support for a child or youth with high needs, the caseworker does not have the right training to offer solutions.
- Foster parents, residential staff, and caseworkers need support, not just training. The work they are doing is difficult and can trigger trauma responses.

PROVIDER BURNOUT

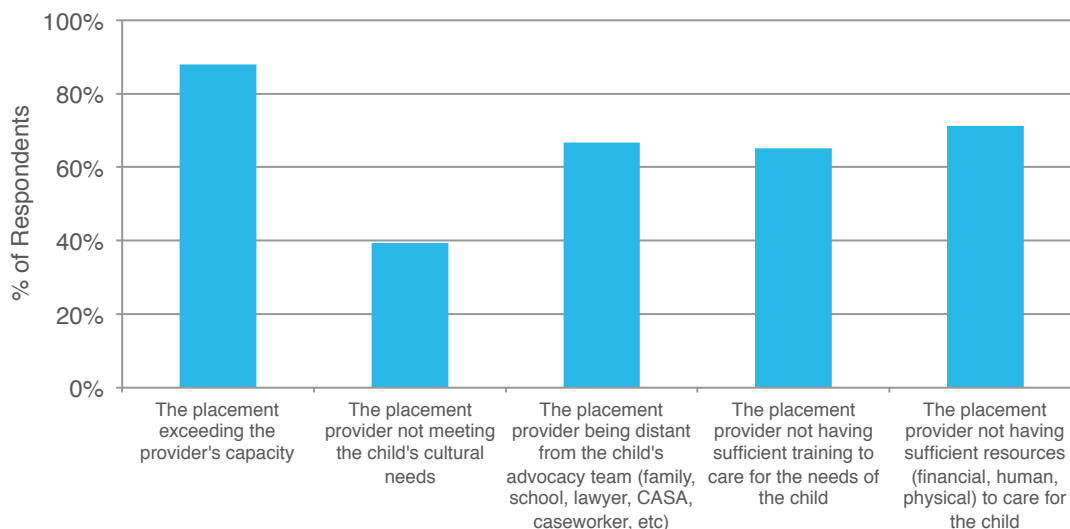
Focus group participants described the implications of not preparing caregivers to serve children and youth with high needs: when children and youth with high needs are in settings that do not have the skills to safely address their needs, there is more turnover within the System because those children and youth typically end up in multiple placements.

Inadequate training and lack of respite options for DHS certified foster parents also leads to poor decision making, burnout, and foster homes leaving the System. Focus group participants report that when foster parents don't receive the support they need to care for children and youth with high needs, they leave, placing increased burden and stress on those who stay.

2.1.4. Finding IV - The urgency to find placements compromises certification and licensing standards.

DHS caseworkers ask substitute care providers (both licensed CCA providers and DHS certified foster homes) to take in children and youth in excess of the foster home's certified or licensed capacity, with some regularity. Over 90% of caseworker and supervisor survey respondents reported that in their work they had observed "the placement exceeding the provider's capacity." Almost 90% of attorneys and judges surveyed for this review reported that they see placements exceeding the provider's capacity occurring in their practice. See Figure 15.

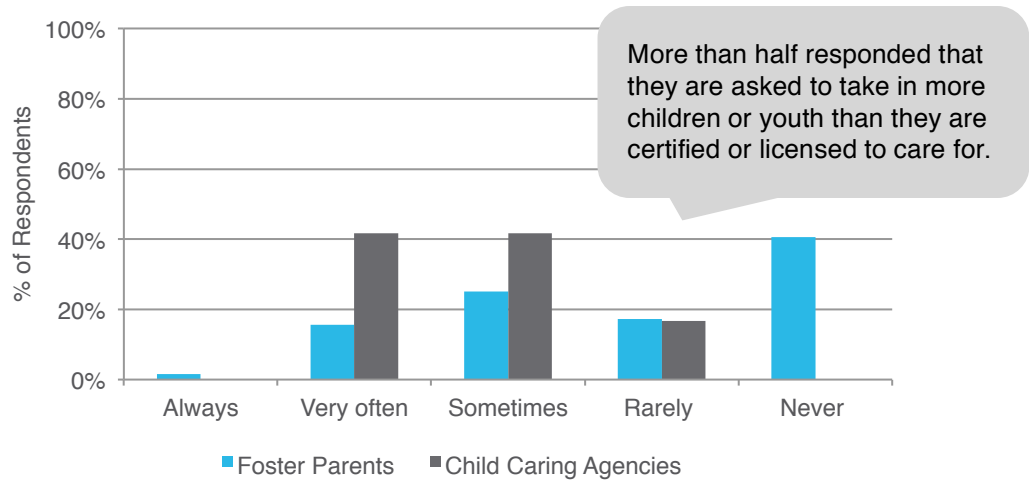
Figure 15: From your experience, which of the following foster care placement situations do you see occurring in your practice? (Attorney and Juvenile Judges Survey Results)



Over half of the DHS certified foster homes and CCAs surveyed report being asked to take in more children or youth than they are certified to care for. See Figure 16. According to foster

parents focus group participants, this issue is exacerbated in rural areas where there are fewer foster homes.

Figure 16: How often has DHS requested you take in more children or youth than you are certified or licensed to care for? (Foster Parents and Child Caring Agencies Survey Results)



According to focus groups, placing children and youth in substitute care placements that exceed the licensing and certification capacity or qualifications compromises the caregivers' ability to safely oversee all the children and youth in their care. Focus group participants reported that a compromised ability to safely supervise the youth in their care could lead to abuse, often between children or youth in the placement. And, exceeding capacity can lead to higher stress and increase the risk of caregivers making poor decisions, which could lead to abuse or allegations of abuse.

FOSTER HOME CERTIFICATION, EXCEPTION PROCESS

Focus group respondents reported that DHS foster home certifiers are being pushed to certify more homes more quickly. Desire to increase the availability of placements of all types may be resulting in DHS certifying foster homes that otherwise would not meet certification requirements.

Our review of high settlement or award lawsuits against DHS revealed that a number of exceptions occurred during the certification of the DHS certified foster homes (which constituted 19 of the 23 lawsuits we reviewed), including: placing an exceedingly high number of children in one home, placing high needs children in homes not qualified to care for those needs, not taking into account past criminal history of foster parents that could affect their suitability for certification, and not adequately considering prior incidences of neglect by foster parents.

Certifiers in a focus group cited weakness in DHS policy and procedure leading to the certification of foster homes that do not meet the technical threshold for denial, but should be denied. Certifiers report that the criteria for review of foster homes do not provide enough reasons for denial, even when a certifier believes there is enough evidence to deny. They report that oftentimes these are the foster homes that become problematic down the road.

Review participants are mixed on whether certifiers have enough or too much discretion when certifying foster homes. Certifiers report they cannot use discretion when they believe they should deny an applicant. Other participants say there is too much local discretion and inadequate standardization of the certification process.

Certifiers estimate that exceptions to certification requirements are used in a majority of new homes opened, mostly for relatives providing emergency foster care. Some focus group participants reported the perception that in rural areas of the state, relative caregivers are “given more leeway” because there are fewer available foster homes.

While emergency certifications and the use of the exception process introduces some risk, certifiers and other review participants also cite the exception process in Oregon as a strength of the System. The exception process enables more relative caregivers to be certified, which is often in the best interest of the child or youth being removed from their home, a preferred placement option to non-relative care.

According to the 2015 CFSR Statewide Assessment Instrument, 46% of children entering care during the 2014 federal fiscal year were eventually placed with a relative, and children were either placed with a relative or there was concerted effort to place them with a relative in 90% of cases (p. 34). In 2011, Casey Family Programs reported that 21% of Oregon’s children and youth were in relative foster care placements (Data Snapshot on Foster Placement, 2011, p.3).

CONCLUSIONS FOR CHILD AND YOUTH SAFETY IN CARE

Review participants indicated that the risks of abuse and other safety issues are elevated if children or youth are placed with a substitute care provider unable to meet their needs.

We heard from almost all assessment participants that demand for all placement types is high and the availability of them is low. Because Oregon does not use an assessment tool prior to placement, nor does the state assess providers for what they can provide, it is not possible to fully understand the gap between need and capacity. This puts all foster children and youth at risk of being placed inappropriately, which can lead to safety concerns.

If a substitute care provider is caring for more children or youth than certified, licensed, or qualified for, safety risks increase for all residents in the placement setting, including other youth and the caregivers.

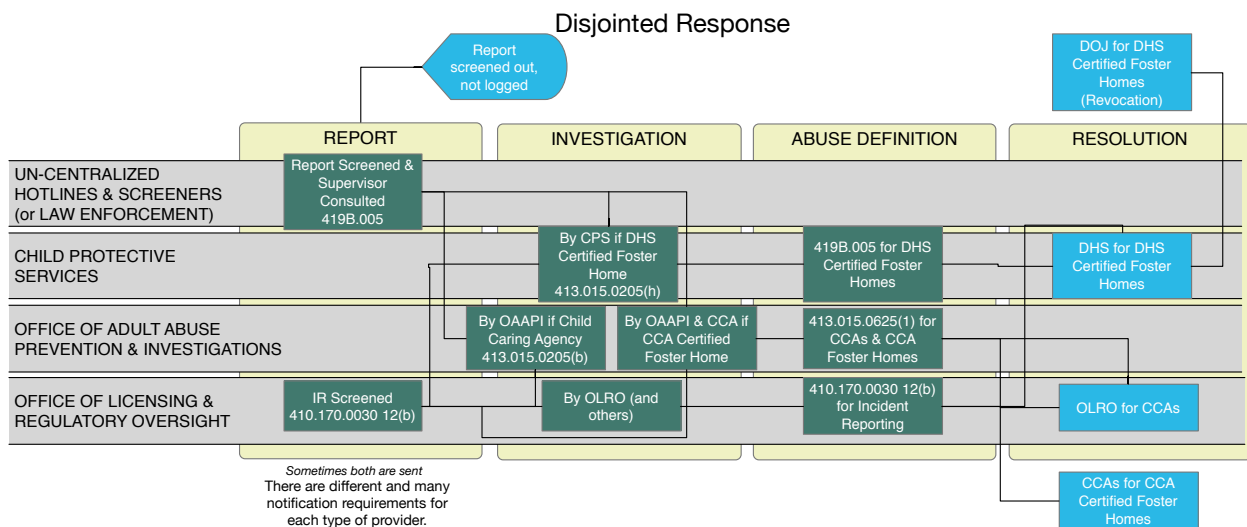
Children and youth with high needs face even higher safety risks related to inappropriate placements. A child or youth with high needs, combined with a caregiver with limited skills to safely meet his or her needs, may increase the likelihood that abuse will occur in that placement setting. Due to the limited and decreasing number of qualified appropriate placements for children and youth with high needs (such as residential placements), typical foster care homes are increasingly being asked to take them in, but with limited skills and support to do so safely.

2.2. Safe and Swift Response to Abuse: A coordinated response to abuse in care could lead to earlier intervention and prevention of future abuse.

2.2.1. Finding V – Oregon’s response to allegations of abuse in care is confusing and involves too many uncoordinated elements.

There are a number of DHS entities, people, statutes, rules, policies, and processes involved in interpreting and applying abuse in care definitions, associated investigation procedures, and rules for critical incident reporting. This has created a confusing and uncoordinated system of response to allegations of abuse in care. See Figure 17.

Figure 17: As-Is Map of Current Response to Reports of Abuse in Substitute Care



Several administrative bodies have responsibility and authority when a potential instance of abuse in care is reported: Child Protective Services (CPS) hotlines in each DHS district or Office of Adult Abuse Prevention and Investigations (OAAPI) determine whether an allegation meets the criteria for CPS assessment/investigation, then the CPS or OAAPI worker determines whether it is founded; the Office of Licensing and Regulatory Oversight (OLRO) or CPS enforces licensing or provider support implications; DHS district caseworkers follow up on the child’s needs, including placement changes, notification of the child’s advocacy circle (e.g., CASA, attorney, therapist, etc.), and updates the case plan as needed.

The review team was unable to find a single individual within this system who understands the entire process of responding to allegations of abuse in care for all provider types. This means

that when a child or youth is abused in substitute care, no single individual has a handle on what should be done, by whom, and by when.

TWO DEFINITIONS OF ABUSE FOR FOSTER HOMES

Oregon defines abuse in a foster home differently based on the entity that certifies the home (DHS certified foster home or a CCA proctor foster home). The rules and statutes that define abuse in a CCA are defined in greater detail because of the unique vulnerabilities of children served and the nature of a residential setting. Yet, this definition also applies to the CCA proctor foster homes, but not to the DHS certified foster homes (DHS Foster Homes: ORS 419B.005, CCA Foster Homes: ORS 418.205).

INVESTIGATIONS OF ABUSE IN CARE

When allegations of abuse in care are reported to the CPS hotline, the screener notes whether the alleged abuse occurred in a DHS certified foster home, or a CCA proctor foster home, and sends the latter reports to OAAPI for screening and investigation (OAR 407-045-0870). The variance in investigation processes between residential facilities and foster home settings may be appropriate due to key differences between the settings (for example residential facilities employ paid clinical and line staff, and the setting by nature is not a home-like setting). However, the same rules that govern OAAPI investigations of CCA residential facilities also apply to investigations of abuse allegations that occur in CCA proctor foster homes. A child or youth could experience the same abuse in a CCA proctor foster home and a DHS certified foster home, but the definition of abuse is different, the agency investigating that abuse would be different, and therefore the subsequent response would vary.

Our review of OAAPI investigator training materials revealed that they receive child-specific training, but their primary charge is adult abuse. A review participant noted that the OAAPI investigators are unable to attend the introductory training for caseworkers to understand the child welfare system and court system within which they are navigating.

Related concerns expressed by focus group and survey participants include:

- There is a perception among some review participants that the heightened focus on abuse in care, stemming from recent media coverage and legislative attention, has increased the amount and intensity of investigations of allegations of abuse done by OAAPI. This impacts both CCA residential facilities and CCA proctor foster homes, but not DHS certified foster homes.

- There is a perception among some review participants that SB 1515, which went into effect on July 1, 2016, has increased expectations for OAAPI investigators and OLRO staff. Some focus group and survey respondents report that OAAPI investigators and OLRO staff are not adequately trained, resourced, and supported to fairly and competently implement the new expectations.

INCIDENT REPORTING VS. ABUSE ALLEGATIONS

Incident reporting is sometimes confused with abuse reporting and often is reported both ways, leading to confusion, redundancy, and potential under or over reporting of actual abuse. This creates a situation that overwhelms DHS, OLRO, OAAPI, and providers. The approach to responding to a critical incident vs. an allegation of abuse is often the same. The criteria for what constitutes a critical incident vs. abuse or neglect is not clear (outside of the definition of abuse and neglect contained in policy language), or is not followed.

Foster parents in focus groups reported that there is no operational definition of “critical incidents” (the current definition is vague and contained in OAR 413-200-0383) and all the foster parents we spoke to use different procedures for handling them. For example:

- Some foster parents document everything in an email or phone call to a certifier or caseworker, (i.e., baby’s fingernail scratched her own cheek).
- Others reported taking pictures of scratches or bruises and emailing them to a certifier with an explanation.
- One foster parent uses a smartphone app to track every incident of physical concern that the foster child experiences.
- Another foster parent had never reported anything because she was not aware of what constituted a critical incident or the procedures for making a report.
- According to DHS foster parents, foster parent training materials say to report an incident if it is “something a mom would want to know about.” This leaves the decision about what to report up to individual discretion.
- Foster parents noted that every certifier and caseworker has different expectations of what should be reported to the hotline versus what should be documented and who should be

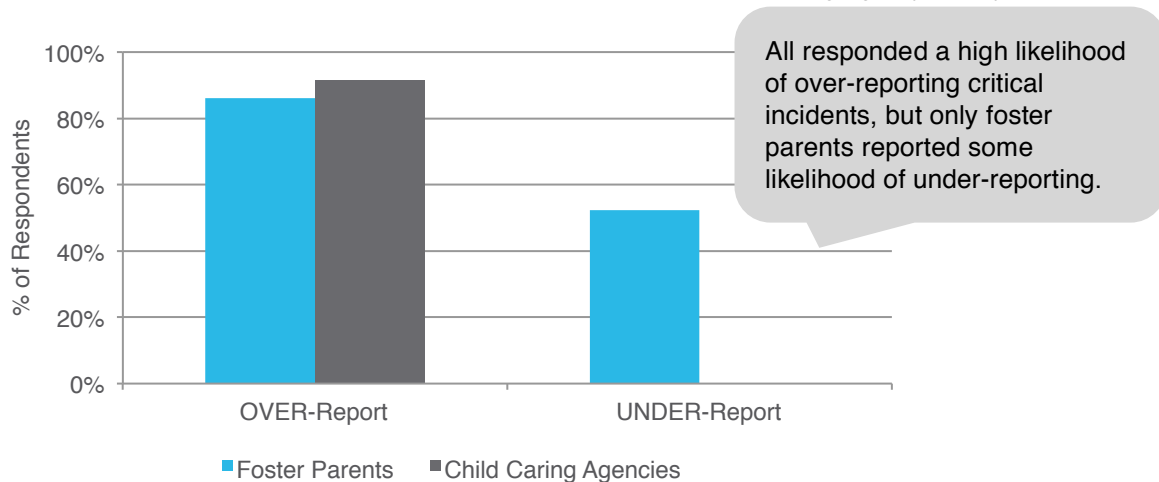
Foster parents indicated that they can lose their certification if they report incidents the “wrong way,” but there is no clear information about what is “the right way.”
- *Foster Parent Focus Group Participants*

notified. One foster parent in a focus group said that there is no middle ground for incident or abuse reports. DHS either does nothing, or opens a lengthy investigation.

There is a definition in rule and policy for critical incident reporting that applies to CCAs (OAR 413-215-0091(12)). However, CCA staff noted that, in order to protect themselves, they report every unusual incident in an incident report and to the abuse hotline, often beyond what the rule requires. CCA staff further report that in the current reporting environment too many (and sometimes all) of these reported incidents are being investigated as abuse or neglect. This has overburdened the staff of the provider agencies and governmental agencies.

As a result of this lack of clarity, it appears abuse in care by both CCAs and foster homes is both under and over reported. See Figure 18.

Figure 18: How likely are you to OVER- and UNDER- report critical incidents due to uncertainty about which circumstances constitute a critical incident? (Foster Parent and Child Caring Agency Survey Results)



Over reporting of critical incidents as abuse in care could be a contributing factor to the high number of calls received by the child abuse hotline that are closed at screening. A high volume of unnecessary reports overburdens staff that must consider and dismiss a number of insignificant incidents. Individual workers’ judgment about true allegations of abuse and neglect may be affected. It is clear that the system does not consistently or accurately discern which reports should be investigated. Our review of the large settlement or award lawsuits revealed that at least six involved multiple reports of abuse that were closed at screening or never fully investigated.

2.2.2. Finding VI - The CPS abuse in care reporting, screening, and investigation process is localized and may result in inconsistent responses to harm in care.

Because the child abuse hotline is decentralized and standardized protocols are not used across districts, response to allegations of abuse may vary depending on where the report was made. Oregon has a single statewide number for reporting abuse (the child abuse hotline), but there is no standard screening protocol that supports consistent decisions across similar cases. Local variation in screening and assessment protocols makes it difficult to eliminate bias and ensure consistent safety decisions are made statewide. According to a recent review, Oregon's practice of "localizing" policies, procedures, and interventions results in inconsistent application of a statewide safety intervention model (OR Safety Model, 2013, p. 1-2). In the words of one focus group participant: the application of DHS screening policies is "as varied as the people" doing the work.

Of the 16 DHS Districts, four provided written protocols to the review team.

- Two outline the Department Rules and two supplement the Department Rules.
- District 2, which covers Multnomah County and District 4 which covers Lincoln, Benton, and Linn counties have supplemental protocols for CPS screening and assessment that provide additional detail on information sharing and coordination between and among DHS staff.
- Additionally, the District 2 protocol specifically requires the caseworker to follow up with the child if a report of abuse or neglect concerning that child was closed at screening, although it does not require the caseworker to do so within a certain timeframe.

Citizen Review Board (CRB), biological parents, and CASA focus group participants expressed discomfort and a lack of confidence with hotline screeners' ability to adequately assess calls to the hotline. Based on their experience making reports about abuse in care to the hotline, they do not believe that screeners receive sufficient training to make consistent and accurate determinations about alleged abuse in care. Fourteen years ago, a PK study found that CPS branches appear to be inconsistent in the abuse screening and assessment criteria that they apply. This appears to still be true today (PK Review, 2002, p. ix).

LOCAL RESPONSE

Focus group participants described situations where caseworkers may intervene at the field level to allegations of abuse and neglect rather than reporting to the hotline, thus reducing the possibility of a formal investigation being launched or consequences for certification or licensing. This practice could be a strength to build upon, if it is an attempt to handle minor

situations with minimal disruption to the child or youth in care. However, because standards for responding to such “minor” situations are not clear, there is no assurance that consistent safety decisions are being made. In focus groups, youth told reviewers stories about caseworkers’ varied responses to reports of abuse, indicating that responses depend on whether they had a good relationship with a caseworker or how long the caseworker had been at DHS.

In some districts it appears that caseworkers are closely involved with investigations. Some focus group participants fear that because those caseworkers are intimately involved with the case, they are not able to objectively assess the situation for abuse or neglect in care.

Foster parents reported taking pictures of scratches and bruises and emailing them to the child’s caseworker, but there does not appear to be a clear protocol for what the caseworker does with that information.

As noted in finding V, CPS and OAAPI have different rules, policies, and procedures regarding investigations and follow-up for allegations of abuse in care, further contributing to the inconsistencies.

HOTLINE STAFF TURNOVER

Survey data from this review corroborates the perception that CPS hotline screeners have a high turnover rate, which may exacerbate the challenges to ensuring consistency. Another consequence of high turnover rates is that historical knowledge about past allegations may be incomplete or lost altogether.

- 22% of screeners surveyed for this review were a CPS hotline screener for less than a year
- 74% have been in their role for three years or less

Multiple participants in this review reported that poor performers at DHS are often re-assigned to hotline positions. Our review team did not assess personnel files to verify the truth of this assertion, however it is significant that a number of individuals inside and outside of DHS hold this belief. Regardless of whether this is or is not common practice, the perception itself speaks to serious issues within the DHS culture as well as external perceptions of the agency.

2.2.3. Finding VII - The current process of abuse in care reporting is rated untrustworthy by youth and other reporters.

Youth and other reporters of abuse in foster care expressed many reasons for not trusting the process for reporting abuse in care. Reasons

“Overall I did not trust that I could report to anyone. What I could trust in was keeping my head low so I didn’t get abused often.”

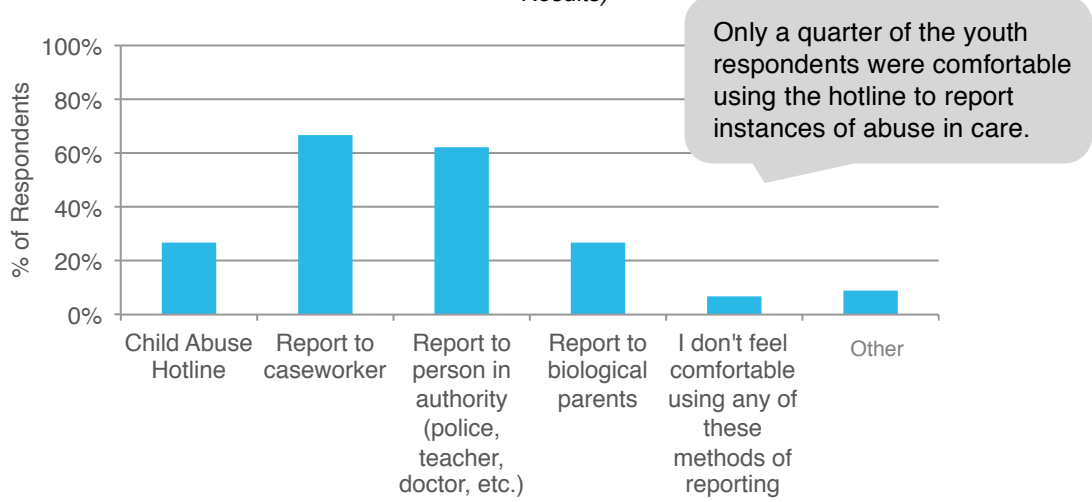
– Youth Survey Respondent

include fear of retaliation, lack of confidentiality, and lack of clarity about what happens after a report of abuse or neglect is made.

Youth in focus groups reported⁹ feeling more comfortable and getting better results when reporting instances of abuse or neglect or discussing safety concerns with a trusted adult outside of DHS, including to a CASA, attorney, law enforcement, or teacher.

Surveys showed that almost 70% of youth report being comfortable reporting abuse to their caseworker. Over 60% are comfortable reporting to another adult authority figure outside DHS. Only about a quarter of them reported being comfortable using the hotline, which is the current official process for reporting abuse in care in Oregon. See Figure 19.

Figure 19: What methods of reporting instances of abuse in care do you feel comfortable using? (Youth Survey Results)



Youth participants in our review (from initial key informant interviews through focus groups and the youth survey) expressed confidence that the Foster Care Ombudsman listens and believes their concerns. Other (non-youth) review participants reported concerns that the Ombudsman is located within DHS, potentially creating a conflict of interest and not being truly independent from DHS leadership influence.

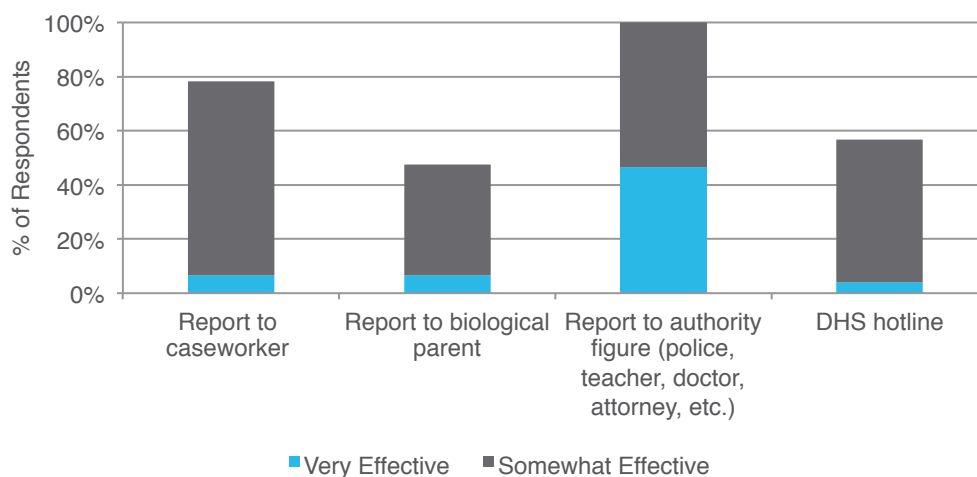
The attorneys and juvenile court judges surveyed for this review indicated that the most effective avenue for children or youth to raise concerns about their placement is to report it to an authority

“As a judge I have not found reports to the hotline to be effective...DHS often codes the report as unfounded, even when a child is unsafe.”
 – *Juvenile Judges Survey Respondent*

⁹ Note there are conflicting reports from youth in this section about their comfort with reporting abuse in care to different entities. On one hand some youth say no one at DHS is trustworthy, but on the other hand a majority of youth survey respondents indicated that they are comfortable reporting abuse to their DHS caseworker. After listening to and reading about the experiences of over 100 current and former foster youth, we believe that there is value in evaluating all of this information. The seemingly conflicting reports are indicative of the confusing experiences of many foster youth, particularly when they suffer abuse in care.

figure other than a caseworker. See Figure 20. 64% of attorneys and judges report the hotline is rarely or only sometimes a reliable way to have concerns heard and responded to.

Figure 20: How effective are the following avenues for foster children or youth to raise concerns about their placements outside of making an allegation of abuse or neglect? (Attorneys and Juvenile Judge Survey Results)



CULTURE OF DISBELIEF

Youth in focus groups reported feeling that the System treats them as “bad” kids who did something wrong to end up in substitute care and doesn’t trust them. A 2015 Critical Incident Initial Response Team Report found a potential systemic issue in “the ability of children in foster care to feel safe about expressing concerns, including concerns about a foster home” (CIRT Initial Report A.M. & R.M., 2015, p. 6).

According to results from focus groups and key informant interviews, there is a “culture of disbelief” toward children in the System and it is set up to discount the child or youth’s experience. Review participants say that some workers determine the validity of a hotline call before all the facts have been gathered. They add that many DHS workers don’t have the time or training to look at a situation from a neutral perspective, and children and youth often don’t feel comfortable talking to certifiers and caseworkers because of their close relationships with foster parents.

Youth reported a lack of confidentiality about their safety concerns. When youth tell their caseworker about abuse or other issues occurring at the foster home, they believe the caseworker often shares the information with the foster parent. Resulting in an unsafe, retaliatory, and uncomfortable environment for the youth.

It may be for good reason that youth do not trust the hotline or DHS to respond adequately to reports of abuse. Youth are not generally considered trusted reporters of abuse within the system, according to survey respondents. The most common reason reported for not trusting youth reports was if a child or youth had made false reports in the past.

2.2.4. Finding VIII - There is little to no follow up on abuse in care investigations.

When a person reports abuse or neglect of a child in a DHS certified foster home using the hotline, DHS's Administrative Rule does not require follow-up to the reporter regarding the outcome of the Department's assessment and whether the allegation was closed at screening (ORS 409.185).

Follow-up is required to the person making the report when the child resides in a CCA residential facility or a CCA proctor home. These are OAAPI-regulated placements (OAR 407-045-0870(4)).

Department rules require OAAPI to notify the child or youth's biological parents or legal guardian, the caseworker, the tribe of an American Indian child, or the Oregon Youth Authority (OYA), when a report of abuse concerning a child in a DHS certified home is made, unless doing so would interfere with the investigation (OARs 407-045-0860(4) and 407-045-0870(1)). However, these parties report not consistently receiving information about reports of abuse and neglect.

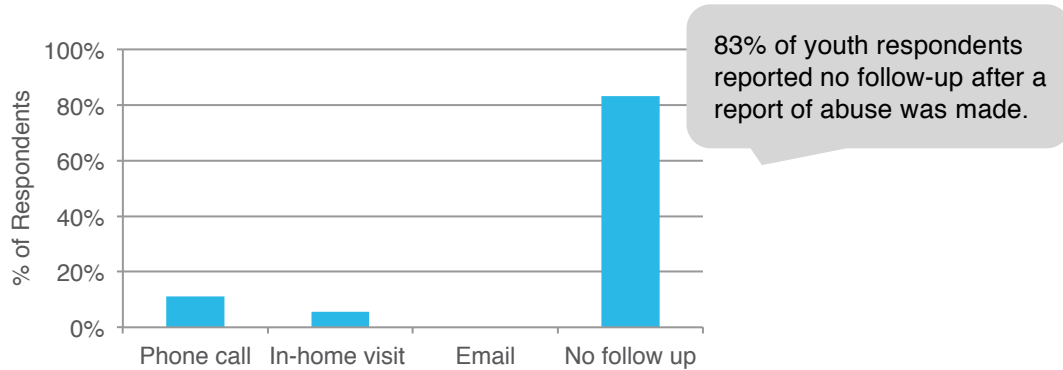
Of the 16 DHS Districts, four provided written screening protocols to the review team, and of those four, only one required the caseworker to follow up with the child after a "closed at screening" allegation.

REPORTERS' EXPERIENCE

Focus group and survey respondents report not receiving follow up after making reports of abuse in care.

- 83% of youth in surveys say they have never received follow up. See Figure 21.
- CASAs in a focus group reported minimal follow up after making reports.
- Biological parents in a focus group reported not being consistently informed when they make reports of suspected abuse or neglect in care.
- 45% of attorney and judges survey respondents stated that the CPS hotline is not an effective avenue for foster children and youth to report concerns.

Figure 21: How have you been kept informed once a report of abuse against your foster home provider has been made? (Youth Survey Results)



Follow up on abuse in care investigations appears to be occurring inconsistently, although the policies are clear.

CONSEQUENCES OF NO FOLLOW UP

No follow up is an issue because the reporter or other members of the child’s or youth’s team do not know if DHS is taking any action, or if the child in question is in an unsafe situation.

“I’ve made a number of hotline calls, I have no idea whether they’ve been investigated or whether the concerns have been responded to.”
 – Attorney Survey Respondent

Youth reported instances of ongoing abuse when DHS failed to follow-up on reports of abuse. One youth reported running away from an unsafe situation before DHS would take her concerns seriously and conduct an investigation.

Foster parents reported receiving no communication during an investigation, other than that they were under investigation. They are not told what the allegation is and receive no communication from DHS during the investigation. Although there may be sound reasons for this to protect the reporter or the child or youth in question, foster parents note that lack of information and the response of moving the child to a new placement can also impact safety and well being.

2.2.5. Finding IX - Information that could mitigate safety concerns is not efficiently shared across the entities involved in keeping children and youth safe.

In 2015, a Critical Incidence Response Team reviewed the case of two children that were severely abused while residing in a foster home. In review, the team noted that there is a

systemic issue in DHS of poor communication within and between branches on co-managed cases (CIRT Initial Report A.M. & R.M., 2015, p. 6).

DHS staff report in surveys that System-wide mechanisms do exist to share information about safety concerns, although this was also an area rated high for opportunities for improvement. Focus group participants reported that information sharing is inconsistent and there are many opportunities for information to fall through the cracks.

- 83% of caseworkers and 67% of hotline staff report there are System-wide mechanisms in place to share information.
- 70% of caseworkers and supervisors reported that improving “IT systems that store and share data” is a top solution for increasing efficiency and coordination between the entities involved in keeping children and youth safe in care (i.e., Child Welfare, CPS, OAAPI, OLRO, and others).

One hotline screener reported using five separate data systems to manage information.

- CPS Hotline Staff Survey Results

DATA SYSTEMS

Oregon currently has a disjointed data enterprise for tracking information about child and youth maltreatment in substitute care. OR-KIDS, the DHS data system, has reporting capabilities, but currently does not have advanced reports set up on the data requested for this review and surrounding child and youth safety in care. This data also is not currently shared or used for trend identification. In the absence of trustworthy data and observable trends, single incident cases and anecdotal information are driving decision-making.

Several separate data systems that do not share information and are of varying maturity levels are used across the System. There are unused fields in the OR-KIDS system that would allow a richer data analysis regarding child safety.

We heard from review participants that the data systems are further limited by staff members that do not input data accurately or in a timely manner. This might be due to training, workload constraints, or other issues. The review team experienced this firsthand: when analyzing data sets we noticed a number of “blank fields” or “unknown” data elements.

FOSTER PARENTS

Foster parents report in focus groups that they often receive little information on a child prior to placement, including mental health history and

“The [Safety Team] found that the lack of communication among DHS staff and/or foster parents contributed to the initial and long term abuse of children in foster care.”

-Oregon Foster Care Safety Team Final Report, p. 4

emotional triggers. One example was the case of a newborn in which the foster parent did not receive information on the infant's birth weight, number of weeks she was born prematurely, and that she was born drug-addicted – all of which would impact the care she should have been receiving.

Foster parents report that DHS staff often does not listen to their concerns or recommendations about a foster child or youth, even though the child is living with them and the foster parent has day-to-day contact.

CASEWORKERS

Caseworkers are required to have contact with children and youth in substitute care that are on their caseloads once per month. According to focus group and interview participants, caseworkers often fail to meet that requirement.¹⁰

Foster parent focus group participants indicated that caseworkers often give incomplete information about children and youth placed in their homes. This could be because they don't know the child, or they may be highlighting their strengths and downplaying their challenges in order to place them. While this may be well intentioned on the part of the caseworker, the foster parent may not know the true needs of the child, increasing the challenge of safely caring for these children or youth.

In focus groups, foster parents report little communication from caseworkers, unreturned phone calls, and often adversarial relationships with them. They report receiving little support, resources, or information from DHS workers to safely care for children and youth in their homes. Most foster parents report turning to their certifiers for support, rather than the child's caseworker.

BIOLOGICAL PARENTS

A focus group of biological parents of children and youth in substitute care report not being believed or taken seriously by DHS. Biological parents feel they are discredited and perceived as having poor parenting skills and not having the best interest of their children in mind, and therefore, are not listened to when communicating safety concerns. They also report not being consistently informed when their children are harmed in care.

¹⁰ As reported in the Statewide Assessment, as of December 2015, 87.46% of contacts with children in substitute care occurred.

2.2.6. CONCLUSIONS FOR CHILD AND YOUTH SAFETY IN CARE

Children and youth experience abuse or neglect the same, regardless of where they live, but the response they experience may be different depending on their placement and caregiver.

Often the wrong allegations are investigated and the ones that should be investigated are screened out. For example, according to Oregon's most recent CFSR Statewide Assessment, in some cases of maltreatment in substitute care there were previous calls [about the case] that were closed at screening or assessed and had a disposition of "unable to determine" (CFSR Statewide Assessment Tool, 2016, p. 16). At least six of the lawsuits we reviewed involved multiple reports of abuse that were closed at screening or never fully investigated. This resulted in abuse escalating undetected.

Findings of abuse are siloed. Isolated communication of crucial facts can lead to safety risks. For example, many cases of abuse and neglect have occurred in provider homes that were never thoroughly assessed and scrutinized prior to certification, according to focus groups and our review of the large settlement or award lawsuits. Other cases of abuse and neglect occurred in provider homes where reports were not accurately documented and spread over several years.

The Department's complex and disjointed system puts children and youth at risk by increasing the likelihood that important facts about safety in care will be overlooked and critical decisions to protect foster children and youth will not be made. In the current system, there is no effective way to ensure that information about abused children or youth does not "fall through the cracks."

3. Related Barriers

This section provides ancillary findings and information about barriers to improving the child substitute care system that arose during the review. Although technically out of scope for this review, we amassed information about these topics during the data collection activities for the review. These barriers, if not thoughtfully addressed and adequately resourced, will hinder progress toward solving the major gaps in the System described in the findings in Section 2. The three areas include data-driven decision making, unreasonable caseloads, and recruitment and retention of substitute care providers. This section also includes observations about disproportionality and minority groups within the system.

3.1. Data Driven Decision Making

ACCESSIBLE, ACCURATE, AND RELIABLE DATA COULD INFORM HOLISTIC SOLUTIONS THAT ADDRESS THE ROOT CAUSES OF HARM IN CARE.

There are few, if any, current reports or protocols set up to share information and data about the safety of placements and providers. The data may exist in the systems, but DHS staff from Department leaders to caseworkers, are not consistently using it to identify trends and make decisions. Limited data-driven decision making leads to reactionary responses based on single incidents and crisis. In the words of one assessment participant, actors within DHS and the System as a whole always feel like they are “putting out a fire.”

IMPLICATIONS FOR CHILD AND YOUTH SAFETY IN CARE

Legislators, DHS leadership, and staff across the System need access to reliable and current data in order to make appropriate decisions that affect the health and safety of Oregon’s children and youth in substitute care. Limited data results in management by single incident cases.

SUPPORTING EVIDENCE

There are several separate data systems currently used by Child Welfare (ORKIDS), OLRO, and OAAPI that do not interface with one another and that are at varying maturity levels.

Oregon is currently dealing with a disjointed and outdated data enterprise system. Producing and evaluating a basic set of performance data is not a part of routine reporting and decision-making. Single incident cases and crisis response are filling this data vacuum, which in turn is driving regulatory and case decisions. These well-intended but partially informed decisions may negatively impact child and youth safety.

Data driven decision-making is instrumental to ensure children are kept safe in care, and, “the absence of such information or presence of irrelevant, insufficient or voluminous and disorganized information results in poor decisions” (OR Safety Model, 2013, p. 14).

The case of Give Us This Day (GUTD)¹¹ is an example of how single incident cases may drive responses when there is a breakdown in the system. As explained in the GUTD Audit, in 2005, DHS made a formal recommendation to not renew GUTD licensing, to stop making referrals, and to remove a majority of the youth residing there. DHS took formal steps to deny renewal of their CCA license. However, DHS leadership at the time made the decision to continue GUTD licensing under a temporary action plan (Audit Report, 2016, p. 2-3) Reasons for this are many, and the state is currently engaged in lawsuits that may bring some of those reasons to light. Contributors to this review believe that political pressure, the provider’s willingness to take in “hard to place kids,” the state’s lack of placement resources, and the state’s fear of appearing racist were primary factors in this case. These factors are not necessarily representative of all the breakdowns in the System leading to children and youth being harmed in care, however this case has instigated responses at multiple levels of the System.

3.2. Unreasonable Workload

REASONABLE WORKLOADS FOR AGENCY STAFF (INCLUDING CPS, OAAPI, OLRO AND OTHERS) COULD IMPROVE CHILD AND YOUTH SAFETY IN CARE.

The Child Welfare League of America recommends a caseworker have on average 12-15 children (not cases) at any time. Only 11% of child welfare agencies across the country are meeting this standard (Workforce Issues in Child Welfare, 2009, p. 4). According to DHS staff, Oregon does not track caseloads by DHS workers. Instead, Oregon uses an activity-based workload model adopted by Oregon’s 78th Legislature. The model tracks the percentage of work being completed by the workforce in a certain timeframe and relies on self-reported time studies. According to DHS staff, the numbers from February 2016 show DHS workers as completing only 83% of needed work (Feb 2016 Workload Allocation Model).

“Caseworkers do their best, but there is just too much to do. They are very overworked.”

– CASA Focus Group participant

IMPLICATIONS FOR CHILD AND YOUTH SAFETY IN CARE

¹¹ Give Us This Day (GUTD) is a former Portland CCA provider recently shut down due to abuse of youth in care and financial scandal. See: http://www.oregonlive.com/politics/index.ssf/2016/01/foster_care_scandal_deepens.html

Inadequate staffing and high workloads for agency staff negatively impact timeliness in case resolution, regular face-to-face¹² time with children and youth in substitute care, and quality safety monitoring.

Focus groups and surveys universally indicated that unreasonably high caseloads and inadequate staffing across agencies in the System are the reasons key safety information falls through the cracks.

According to recent reports, high caseloads for Oregon DHS often prevent child welfare workers from spending face-to-face time with families (CFSR Annual Progress Report, 2014, p. 102). However, there is no way to ensure safety of children in substitute care without seeing them in those placements. Particularly because Oregon's children and youth experience abuse in care at higher than national rates, face-to-face contact with their caseworkers is even more critical.

A 2002 report showed that CPS staff workloads are a critical factor affecting the quality, accuracy, and timeliness of child safety decisions (PK Review, 2002, p. vii). According to review participants, this is still true today.

SUPPORTING EVIDENCE

In the last five years, 23 lawsuits have been brought against DHS that revealed numerous violations of policies and procedure. Our review of those cases revealed: failure to adequately investigate repeated reports of abuse, failure to make contact with children to assess safety and wellbeing, failure to document and investigate observed injuries, failure to inform foster parents of foster children's behavior and health history, and failure to maintain coordination between caseworkers. All of these breakdowns could be partially attributed to high workloads and understaffing.

As reported elsewhere in this report, the proportion of children and youth in the System with high needs has increased, resulting in a workload increase across the System.

Foster parents and youth reported in focus groups and surveys that high turnover among caseworkers and infrequent face-to-face contact makes it difficult for children and youth to build trust with the caseworker. Children and youth who don't trust their caseworker may be less likely to report safety issues.

**"I have never had a caseworker answer the phone when I call."
—Focus Group Participant**

¹² As of December 2015 87% of required face-to-face contacts with children occurred (CFSR Statewide Assessment Instrument, 2016, p. 42).

Focus group and survey participants across the board expressed the perception that caseloads are high, preventing caseworkers from spending the required face-to-face time with children and youth in substitute care. According to the Safety Intervention System Review, Oregon's workload situation far exceeds the outdated national standard (Oregon Safety Model, 2013, p. 1).

3.3. Recruitment and Retention of Providers

COORDINATED AND ENHANCED RECRUITMENT AND RETENTION ACTIVITIES FOR ALL SUBSTITUTE CARE PROVIDER TYPES COULD REDUCE PRESSURE TO PLACE CHILDREN AND YOUTH INAPPROPRIATELY.

Participants in the review, from key informant interviewees, to survey and focus group participants, and to advisory committee members agree that the state is not doing enough to recruit and retain substitute care providers.

IMPLICATIONS FOR CHILD AND YOUTH SAFETY IN CARE

DHS does not have a comprehensive statewide recruitment, retention, and support plan for substitute care providers, which results in inconsistent and inadequate efforts to sustain and grow placement options of all types.

In the short term, this results in children and youth being shuffled between homes, hotels, and in some cases even sleeping at local DHS offices. See Finding I.

In the long term, this situation increases the likelihood of an inappropriate placement, low quality care, exceptions to certify less-qualified foster homes, or abuse and neglect.

SUPPORTING EVIDENCE

Multiple focus group participants agree that lack of placements of all types is a serious problem across the state, in both rural and urban areas alike.

Foster parent focus group participants reported multiple factors contributing to foster parents leaving the system, including: caring for more children than they were certified to care for, insufficient training, little support from DHS, and lack of respite care when needed. In surveys, foster parents added: lack of subsidized daycare (especially for relative providers), low provider payment rates, and the scheduling demands placed on foster parents who need to work to meet certification standards.

“The State does not have a statewide process in place to ensure the diligent recruitment of foster homes, despite significant shortages of all types of foster homes.”
- *CFSR Executive Summary, 2008*,
p. 16

DHS-certified foster parent focus group participants reported that they were not “recruited” by DHS, but rather had reached out directly to DHS, or were recruited through friends. Others were recruited by Embrace Oregon, a faith-based partner of the foster care system.

Some localized efforts and campaigns are underway to recruit foster families, but no statewide strategy exists, nor is there a separate budget or resources dedicated to this work.

Almost a third of DHS staff surveyed indicated that *there is no entity* in charge of recruitment and retention of foster homes. DHS certifiers in a focus group reported that “everyone is in charge of recruitment and retention,” which effectively means no one is responsible.

The perceptions and the climate surrounding the reasons for and implementation of SB 1515 have resulted in increased tensions between DHS licensing staff and CCA staff. Focus group participants report that the statute’s expectations, particularly around the financial oversight, have changed the relationship from collaborative to authoritative. According to review participants, this has implications for recruitment and retention of licensed CCA providers.

It is not clear from looking at the data from DHS whether the supply of foster homes is decreasing or staying steady. According to the recent CFSR Self Assessment, there was a decrease of 20% of general foster homes between 2013 and 2015 (CFSR Statewide Assessment Tool, 2016, p. 118). Yet, the data we reviewed from the DHS system does not corroborate this. According to the data from DHS it appears foster home numbers are staying stable from year to year, but there is significant “churn” within Oregon’s pool of foster homes: the data shows that Oregon is closing approximately 1,500 foster homes each year, and opening close to 2,000 (PK Data Request from DHS, 2016).

3.4. Minority Groups and Disproportionality in the System

This section provides ancillary observations the independent review team made about the System’s sensitivity to cultural and sexual minority groups within the population of children and youth in care. These are not findings because the review team was unable to draw conclusions about these areas from the data we collected. See Section 5.3 Constraints. These may be areas the state should consider exploring further during the process of addressing gaps in the System.

3.4.1. Cultural competency issues within the System may have implications for safety in care.

Few participants in focus groups or surveys identified issues of equity or cultural competency to be significantly connected to safety in care. See Section 5.3 Constraints. However, youth, providers, and other advocates who have experienced this disconnect firsthand spoke about cultural competency and culturally sensitive placements for children and youth as factors affecting safety in care.

CULTURALLY COMPETENT PLACEMENTS

Cultural competency language is woven throughout the DHS child welfare policies and procedures, but policy alone cannot address implicit biases that some staff and caregivers carry with them.

Focus group participants stated that DHS does not consider race, culture, or sexual orientation or identity in placement decisions. After analyzing data from focus groups, surveys, documentation, and data systems, it appears this is true.¹³ Several factors may contribute to this:

- Dearth of placement options across the board
- Gaps in data collection, training, and communications that impact the way race and culture inform policy and decision making within the System

DHS staff on the Internal Resource Committee reported that there is work being done to address implicit bias across the system. According to DHS staff, the agency offers some optional training including Undoing Racism and Lets Talk About Race. See Section 3 Recommendations for more on this type of training.

DISPROPORTIONALITY

This review did not include in-depth analysis of the impact of disproportionality on child safety in substitute care. However, data shows that there is disparity in the system, in terms of the proportion of children of color. Approximately 20% of children and youth in foster care are of color, while children of color make up only 11% of Oregon's overall child population (Governor's Task Force on Disproportionality in Child Welfare Final Report, 2011, p. 5).

¹³ The notable exception to this is children placed under the Indian Child Welfare Act, or ICWA, which requires placement decisions to consider federal recognition status of tribal membership.

The 2011 Governor’s Task Force on Disproportionality Report provides detailed information about the disproportionality issues Oregon is currently facing. We suggest DHS use the results of the Task Force on Disproportionality Report in its work to address system gaps in the areas of safe and appropriate placements and safe and swift response to abuse in care. While most of the recommendations in the report focus on broad, institutional changes, the report also recommends specific steps to address workforce issues, such as prioritizing recruiting and retaining a diverse workforce and requiring ongoing training for child welfare workers, supervisors, and leaders focused on “implicit bias and structural racism, family engagement and inclusion, and team decision making” (Governor’s Task Force on Disproportionality in Child Welfare, p. 22). Specifically, the review team suggests Oregon focus on the following recommendations to address safety in substitute care and the findings detailed in this report:

- **DHS Workforce Development.** Establish working relationships and partnerships, hiring and retention practices, and culturally responsive training.
- **Policy and Practice.** Develop an objective risk assessment tool, enhance existing foster and relative placement support, and expand the racially and culturally diverse pool of relative and non-relative foster home resources.
- **Data-Driven Decision Making.** Set targets, improve system effectiveness, and develop research-informed decision-making process (Governor’s Task Force on Disproportionality in Child Welfare, p. 32).

3.4.2. Awareness of and services for LGBTQ children and youth in substitute care appear to be minimal.

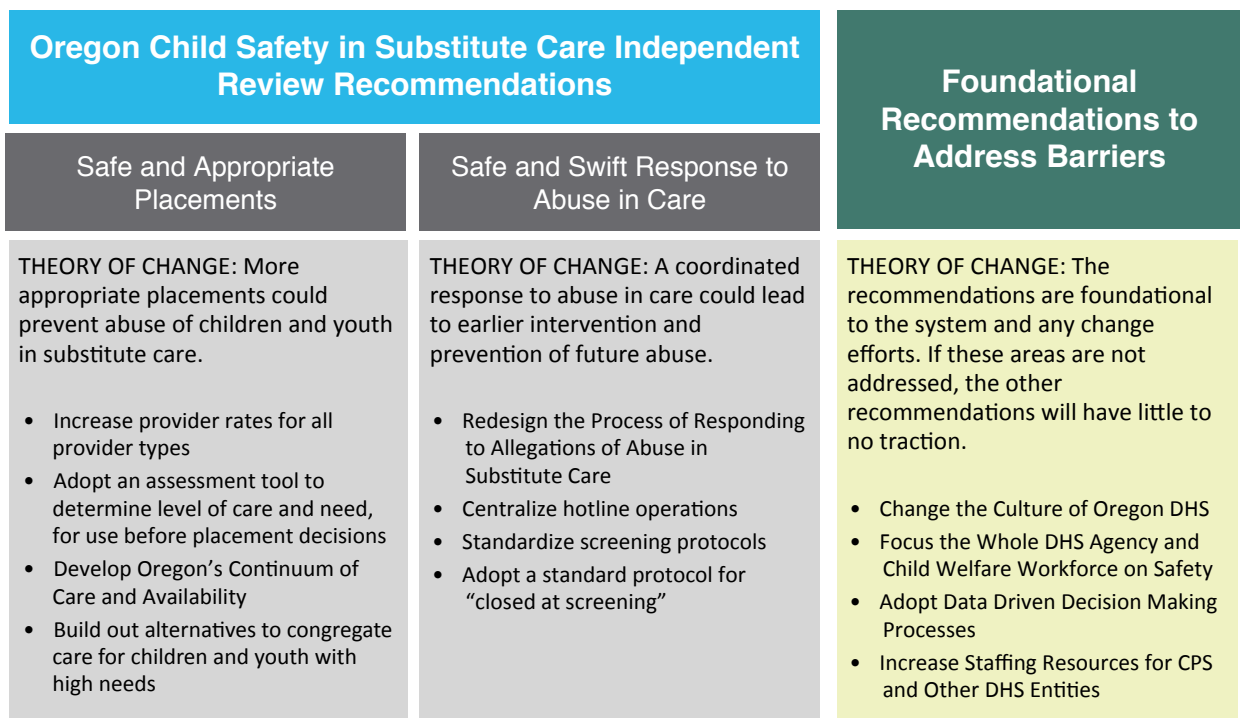
Focus group participants, including youth, foster parents, and CASAs noted that placing lesbian, gay, bisexual, transgender or queer (LGBTQ) children and youth with substitute caregivers who understand and support them enhances their safety and overall experience in care. They cited instances of LGBTQ youth in a non-supportive environment being threatened by foster parents and other youth in the home, and experiencing isolation and depression resulting in self-harm and behavioral problems. In addition, these focus group participants discussed a lack of LGBTQ-related training for foster parents and DHS staff, making it difficult for these children and youth to connect to necessary services. One foster parent stated: “sexual minorities are invisible to DHS.”

We learned from a focus group with CCA foster parents, that some agencies actively recruit for foster parents in the LGBTQ community. This could be considered as part of an overall recruitment strategy.

4. Recommendations

The following recommendations are provided to system stakeholders, including Oregon’s Office of the Governor, Oregon DHS, and the Oregon Legislature. The recommendations are possible solutions to transform Oregon’s substitute care system by leveraging strengths and addressing gaps. Estimated cost level is included, as DHS will need funding and resources to implement most, if not all, of the recommendations in this report. Figure 22 is a map showing the recommendations. The theory of change is the independent review team’s estimation of the outputs of implemented recommendations and the long term desired outcomes.

Figure 22: System Change Logic Model



4.1. Implementation Resources

THE STATE NEEDS TO FUND RESOURCES REQUIRED TO FIX THE PROBLEMS WITH OREGON’S CHILD SUBSTITUTE CARE SYSTEM.

DHS will need funding and resources to implement most, if not all, of the recommendations in this report and others. There is momentum in the state to fix the problems with the System, but change will not happen without people dedicated to implementing solutions.

Implementation of the recommendations in this report and other initiatives will be time and labor intensive, and DHS staff do not have the capacity to add this work to their regular jobs. Implementation resources will be needed to accomplish the following:

- **Resource planning.** DHS, together with the Governor and the Legislature, should prioritize the recommendations in this report and others, and develop a resource plan to staff the efforts.
- **Alternatives analysis.** The review team provided examples in this section of tools and best practices we have seen work well in other states or that are recommended by national organizations, but Oregon will need to engage in alternatives analysis upfront to determine what will work best in the context of this state.
- **Management of the change efforts.** DHS will need an implementation management team, to operationalize many of the recommendations. An implementation manager or team will need to develop an implementation plan, manage the implementation of the plan, and measure success.
- **Engagement of experts.** The state will need access to outside expertise and resources to implement some of the recommendations in this section as well as other initiatives. This could range from working with the Capacity Building Center for States to access free technical assistance and capacity building, Chapin Hall to improve the use of child welfare data, engaging policy experts to redesign the process of responding to allegations of abuse in care, and working with implementation experts to ensure the efforts gain traction and create lasting change.

4.2. Safe and Appropriate Placements

Over the course of this review, the topic of quality providers and availability of providers of all types came up over and over again. Although our team did not review quantitative data that verifies a shortage of substitute care providers, review participants reported this perspective almost universally. Key to Oregon’s success in reducing the number of children in substitute care who experience abuse is changing the payment model for providers, appropriately matching children and youth to the right level of care, developing a more robust continuum of care, and building out alternatives to residential care for children and youth with high needs.

4.2.1. Priority Recommendations

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
Increase Provider Rates for All Provider Types	The state should review provider rates and make sure they are commensurate with the services providers are being asked to provide. Multiple stakeholders pointed to provider payment rates and methodology being a significant barrier to attracting and keeping qualified providers. Oregon should look at directing more funds towards this at every level of care. For comparison purposes, a 2012 survey outlined foster care payments across the country in terms of rates, modifiers, and models (State Child Welfare Policy Database, 2016). This may help provide support and direction for increasing rates in Oregon. In this

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
	<p>report, Casey Family Programs found, “The basic foster care rates in the majority of states fall below our estimate of the costs of caring for a child” (DeVooght & Blazey, 2012, p.2).</p> <p>In order to appropriately match children and youth to substitute care providers, Oregon should also consider changing the foster care level modifiers for payment from purely child or youth needs driven to provider skill driven as well. For instance, a child or youth who needs level 3 foster care should be placed with a level 3 provider who has specialized training and skills to handle those needs. This would also necessitate completing a level of care assessment before placement decision as often as possible (see next recommendation), while also not relying on a pre-placement that would cause more placements overall.</p> <hr/> <p>Initial Resources:</p> <p>Rate Fact Sheets: http://www.childwelfarepolicy.org/maps/reimbursement_fact_sheets</p> <p>Payment Rate Report: http://www.childtrends.org/wp-content/uploads/2013/04/Foster-Care-Payment-Rate-Report.pdf</p> <hr/> <p>Estimated Cost Level: ¹⁴</p> <p><input checked="" type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral</p>
<p>Adopt an Assessment Tool to Determine Level of Care and Need, for Use Before Placement Decisions</p>	<p>Adopt and implement a front-end assessment tool to support decision making for appropriate placement. Such a tool will support caseworkers and teams to determine the intensity, duration, and restrictiveness of services before a placement is made, reducing the risk of harm in care due to inappropriate placements. There are a variety of tools that can be used (as well as states that have developed their own). The review team recommends Oregon adopt the use of CASII/ECSII for level of care determinations. These tools assist most in the initial determination of need, but also assist states to balance between individual clinical need and resources available across the state. The tool has six levels that correspond to medical need and level of care, from basic needs to 24-hour secure medically managed services.</p> <p>Note: “Levels of care (LOC) should be determined by the child’s needs and strengths and be connected to level of funding. LOC should not determine type of placement. For example, recent research on in-home services and treatment foster care indicate that children with severe needs can be appropriately treated with effective supportive services” (Stratton, 2005). For example, a child or youth with a high level from a CASII assessment can still be maintained in a specialized foster home or relative care with the right in-home services and supports in place.</p> <hr/> <p>Initial Resources:</p> <p>Levels of Care: https://www.openminds.com/wp-content/uploads/indres/010105levelsofcare.pdf</p> <p>Payment Rate Report: http://www.childtrends.org/wp-content/uploads/2013/04/Foster-Care-Payment-Rate-Report.pdf</p> <p>CASII: https://www.aacap.org/App_Themes/AACAP/docs/member_resources/practice_information/casii/CASII_infor_and_data.pdf</p> <hr/> <p>Estimated Cost Level:</p>

¹⁴ The estimated level of cost is a rough estimate based on the review team’s experience with or observations on similar undertakings in other states.

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
<p>Develop Oregon’s Continuum of Care and Availability</p>	<p style="text-align: center;"> <input checked="" type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral </p> <hr/> <p>Planfully consider the levels of care needed and provided in the state. The continuum of care begins with in-home services so children and youth can stay safely at home, to relative foster care, to non-relative foster homes, to crisis care, to specialized or professional foster care, to therapeutic foster care, residential, and psychiatric residential treatment facilities. This should be done with a focus on continuing to keep congregate care numbers low, and reducing the state’s out of state placements that have recently increased (see Figure 11). Oregon must ensure adequate availability at all levels of care, which is possible only if there is data about the level of care needs of the population and the level of care skills and abilities of the providers (using an assessment discussed above). “Simply reducing the use of congregate care without developing alternatives runs the risk that many of these youth will be thrust into environments where their caretakers may not have the skills, capacity, or training to meet their needs” (California Child Advocates for Change, 2016, p.5). See more information on efforts like this in Connecticut, Colorado, Tennessee, and Nevada.</p> <p>Finally, the current placement services available for children and youth involved in Oregon’s substitute care system are confusing. Finding a way to simplify this continuum of care and focus on quality and quantity is critical. At this time, depending on which service the child or youth needs, different agencies, processes, and oversight are brought to bear. Some of this is necessary, but some seems to have been created by rule and unnecessary bureaucracy around the services.</p> <hr/> <p>Initial Resources:</p> <p>Continuum of Care: https://www.childrennow.org/files/6514/6896/7658/Foster_Care_Policy_Brief_-_Developing_a_Robust_Continuum_of_Care.pdf</p> <p>Continuum of Care State Examples: https://www.childwelfare.gov/topics/outofhome/foster-care/achieving-continuum/#sl_examples</p> <p>Reducing Congregate Care: http://www.childrensrights.org/wp-content/uploads/2011/07/2011-07-25_what_works_reducing_reliance_on_congregate_care_in_tn_final-report.pdf</p> <hr/> <p>Estimated Cost Level:</p> <p style="text-align: center;"> <input checked="" type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral </p>
<p>Build Out Alternatives to Congregate Care for Children and Youth with High Needs</p>	<p>Oregon has a relatively small population of children and youth in residential or congregate care (U.S. Department of Health and Human Services, 2015, p.14). While this is a strength of the System, it has also caused some harm, as many children and youth with high needs are being placed in lower levels of care that are not able to adequately or safely care for them. Oregon needs to build out a model of non-congregate care to serve these children and youth with high needs. There are many models across the country including some of the most successful: Therapeutic Foster Care (TFC) (including an international organization specializing in developing TFC that is based out of Oregon), Intensive Wraparound¹⁵, and Care Management Entities. Oregon needs to choose which one(s) to establish within the state. This is for likely a very small part of the substitute care population, but they are among the neediest and most expensive to serve. Although expensive to build out and implement, these services will save money in the long term as</p>

¹⁵ This was piloted in Oregon and some sites still use it, but it is not used statewide. <https://www.oregon.gov/oha/amh/data/scwi2013biennial-leg-report.pdf>, page 4 - This Statewide Children’s Wraparound Initiative report fulfills the requirement in ORS 418.985 (4). Statewide Children’s Wraparound Initiative Biennial Legislative Report May 17, 2013, <https://www.pdx.edu/ccf/sites/www.pdx.edu.ccf/files/Best%20Practice%20Guide%20Version%201.0.pdf>

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
	<p>they are less expensive to operate, produce better child outcomes than congregate care, and will result in less harm in care because children and youth will be in the appropriate placements.</p> <hr/> <p>Initial Resources:</p> <p>Treatment Foster Care: http://www.imis100us2.com/ffta/FFTA/Learn/What_Is_Treatment_Foster_Care_/New_FF_TA_Content/Learn/What_Is_Treatment_Foster_Care.aspx?hkey=b72589aa-0fa2-45ca-8586-b25939566e3b</p> <p>TFC Consultants: http://www.tfcOregon.com/</p> <p>Statewide Wraparound Initiative: https://www.oregon.gov/oha/amh/data/scwi2013biennial-leg-report.pdf</p> <p>Best Practices in Wraparound: https://www.pdx.edu/ccf/sites/www.pdx.edu.ccf/files/Best%20Practice%20Guide%20Version%201.0.pdf</p> <p>Care Management Entities: http://www.chcs.org/resource/care-management-entities-a-primer/</p> <hr/> <p>Estimated Cost Level:</p> <p><input checked="" type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral</p>

4.2.2. Other Recommendations to Consider

Outside of the four priority areas discussed in the above section, Oregon may choose to consider other best practices and recommendations once the priority recommendations are addressed. These include:

- Add more accountability into the foster home certification exceptions process.** Both benefits and risks related to the exceptions process were reported during the review. The exceptions process should be used to ensure relative care when appropriate, but safety requirements for non-relative care should not be subject to the exceptions process often, if at all. The review team recommends that DHS add in another level of accountability to the exception process and related rules and policies. For example, the OAR governing certifications does not require documentation for all safety-related exceptions (OAR 413-200-0274). Documentation should be completed for any exception related to a safety requirement. DHS should tighten the requirements and process to ensure District Managers are approving waivers for all safety exceptions, while still balancing the need for flexibility in the exceptions process to support relative placements. We recommend that this function remain a decentralized activity, as local staff will still see first hand the homes they are considering for certification. However, Oregon should adopt a centralized quality assurance

function (such as regular audits completed by the central office) to ensure the appropriate decisions are being made at the local level.

Initial Resources: N/A, PK recommendation

- **Continue relative placements and use Family Finding.** While relative placement in Oregon is considered a strength of the System, there is still room to grow this placement type. Focused efforts on finding relative placement resources early in the case and getting them approved to care for children and youth should continue and increase. This will involve streamlining the process to remove unnecessary barriers to certification of relative care providers, but without compromising safety standards. We were unable to determine whether Oregon consistently works with Family Finding¹⁶ or other similar research services to search for relative placement resources. If these services are used sporadically or only in some areas of the state, DHS should consider adopting this as standard practice.

Initial Resources:

Family Finding and Engagement: <http://www.childrensdefense.org/library/data/promising-approaches.pdf>

Relatives and Kin:

<https://www.childwelfare.gov/topics/outofhome/kinship/locating/searching/>

Family Finding Search Tools: <http://www.familyfinding.org>

- **Train and infuse trauma informed care into the System.** Review participants from across the System indicated a need and desire to infuse trauma informed care. "Providers and systems have the ability to help or potentially re-traumatize. A trauma-informed system aligns interactions among youth-serving agencies, such as the child protection systems, lawyers, juvenile judges, law enforcement, schools, and mental health providers so that they better understand how youth, families, and adults respond to trauma" (IWGYP, 2013, p.4). It is essential that the System caring for children and youth in substitute care have extensive knowledge and training in trauma and trauma informed care. Understanding and skills in this area will help to de-escalate tensions in the homes and placements and keep more children and youth safe.

¹⁶ "The Family Finding model, developed by Kevin A. Campbell, offers methods and strategies to locate and engage relatives of children currently living in out-of-home care. The goal of Family Finding is to connect each child with a family, so that every child may benefit from the lifelong connections that only a family provides."

Initial Resources:

Trauma-Informed Systems: <http://www.nctsn.org/resources/topics/creating-trauma-informed-systems>

Creating Trauma-Informed Systems: <http://www.extension.umn.edu/family/cyfc/our-programs/ereview/docs/cmhereviewMar11.pdf>

Trauma-Informed Practice: <http://calswec.berkeley.edu/toolkits/child-welfare-mental-health-learning-collaborative-katie/trauma-informed-practice-tools>

Child Trauma Academy: <http://childtrauma.org/>

- **Ensure providers have access to respite.** Respite care is a key factor in supporting and retaining foster parents, and ensuring that caregivers are able to safely care for the children and youth in their homes. Policies that allow foster parents to use their natural supports, such as neighbors, family members, and family friends, as baby-sitters and respite providers can be particularly helpful. There are many model respite care programs from Mockingbird Family Model (WA), or Circle of Support (VA), to public and private networks pooling funds and providing vouchers. It is critical that Oregon establish something to support these families when a break is needed to de-escalate.

Initial Resources:

Mockingbird Family Model: <http://mockingbirdsociety.org/index.php/what-we-do/mockingbird-family-model>,
http://calswec.berkeley.edu/sites/default/files/uploads/effective_practices_in_foster_parent_recruitment_and_retention.pdf, page 13

Circle of Support: http://www.nrcdr.org/_assets/files/NRCRRFAP/resources/taking-a-break-respite-guide.pdf, page 17

- **Implement exit interviews with providers leaving the system.** A relatively low cost way for DHS to get quick feedback on what works and what does not work for providers is to implement exit interviews or exit surveys to find out why a provider is ending their service.

Initial Resource:

Example survey: <https://www.surveymonkey.com/r/fosterparentexitinterview>

- **Focus on keeping more children and youth at home with supports in place.** Although not the focus of this report, there is no doubt that preventative work with families to keep children and youth safely at home and out of substitute care will ease the demand in the System. As a few review participants put it, “there is no reason these children and youth shouldn’t be at home if we can’t keep them safe.” A focus on court and state intervention while the child or youth is still at home (in appropriate cases) with supports and services in place will help.

Initial Resources: N/A, PK recommendation

4.3. Safe and Swift Response to Abuse in Care

The ability to swiftly respond to the correct abuse in care allegations and keep children and youth safe will center around stakeholders’ ability to see this set of steps from the perspective of a child or youth. The entire process has to become more standardized and less complicated in order to keep critical safety information from “falling through the cracks.” This includes redesigning the process of responding to allegations of abuse in care, hotline operations, screening protocols, and closed at screening decisions.

4.3.1. Priority Recommendations

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
<p>Redesign the Process of Responding to Allegations of Abuse in Substitute Care</p>	<p>A number of DHS entities, people, statutes, rules, policies, and business processes are involved in responding to abuse of children or youth in substitute care. The abuse in care definitions, associated investigation procedures, and rules for critical incident reporting, create a confusing and uncoordinated response system. The independent review team could not find a provider or DHS employee who could explain all of the details of these processes for all provider types, which means that when a child or youth is abused in care, no single individual has a handle on what should be done, by whom, and by when. It appears that this convoluted system has led to safety information “falling through the cracks,” allowing abuse in care to continue in some cases. Fixing individual elements of this process, such as instituting one definition of abuse for all substitute care settings or improving training for investigators, will not fix the convoluted nature of the current system.</p> <p>We recommend that Oregon redesign the process, beginning with the perspective of the child or youth in care. We believe this is more than a business process redesign project. It will require an effort to rebuild the process from start to finish, including associated rules, policies, and statutes. In order to accomplish this, the current processes should be documented, focusing on understanding the current requirements, their origins, and the reasons behind the requirements so DHS knows what needs to be kept and what should be updated or replaced. Because no one person understands the system from beginning to end, skipping this step could mean something important is missed. That said, the focus should be on redesigning this process from start to finish and it should look completely different than it does today, as the current process is not working and is not child or youth driven.</p> <p>Elements for this effort should include:</p>

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
	<ul style="list-style-type: none"> • Document as-is processes, focusing on the current policies, rules, and statutes. Use the PK Regulatory System Maps as a high level starting place for this effort. • Develop to-be processes. Identify and develop policies and procedures that support a future state driven by the child or youth experience. • Engage the appropriate legislative entities to assist with clarifying existing or developing new statutory language. • Determine changes to staffing, organizational structures, training, cost models, and data collection and reporting needed to support the new processes. • Engage external technical assistance to advise and facilitate this effort. • Assign appropriate DHS staff to support the effort. We recommend including a balance of DHS staff who have worked in the current system and also individuals who will think disruptively and promote change. • Ensure representatives from all provider communities are consulted (CCA, DHS certified foster homes, CCA certified foster homes, residential programs, PRTFs, etc.). • Treat this as a project with established goals, timelines, and assignments. <hr/> <p>Initial Resources: PK Deliverable 2.2 Authority Inventory and Regulatory System Maps. The authority inventory captures many of the current statutes and rules related to the child substitute care system. The two system maps summarize the process from a regulatory standpoint for responding to allegations of abuse in DHS certified foster homes and CCA substitute care settings.</p> <hr/> <p>Estimated Cost Level:</p> <p style="text-align: center;"> <input checked="" type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral </p>
<p>Centralize Hotline Operations</p>	<p>The review team recommends centralizing the hotline operations and standardizing training and response criteria to add consistency to screening and decision-making, standardization of processes, ease, better oversight, and clarity on responsibilities so less falls through the cracks. There are certainly pros and cons to decentralized and centralized hotline models, but the review team believes that for Oregon, there are more benefits to centralization than consequences.</p> <p>Benefits to a centralized hotline include: more cases identified and more victims confirmed, a higher percentage of referrals that are screened-in (compared to decentralized models), a lower percentage of referrals screened-out (compared to decentralized), brings consistency to the way abuse and neglect calls are managed, improves the intake specialist’s ability to gather information from caller, expedites the process of preparing reports and dissemination to local office for assessment, and allows local offices to spend more time working with children and families because they are no longer responsible for handling intake functions.</p> <p>The review team identified model state policies and resources to help with this change, listed in the Initial Resource row below. The state should conduct an alternatives analysis to select the model most appropriate for Oregon’s specific needs.</p> <hr/> <p>Initial Resources:</p> <p>State policies that can be referenced as models: Florida, Colorado, Indiana, Michigan,</p>

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
	<p>Utah, Idaho, and more.</p> <p>Answering the Call: How States Process Reports of Child Abuse and Neglect</p> <hr/> <p>Estimated Cost Level:</p> <p><input type="checkbox"/> Cost intensive <input checked="" type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral</p>
<p>Standardize Screening Protocols</p>	<p>The best practices in screening protocols include: When an abuse report is received on a child in substitute care, "the intake process must distinguish between reports that: do not indicate maltreatment or concerns about standards of care, and require no further services; do not indicate maltreatment or concerns about standards of care, but do identify the need for further services; do not indicate maltreatment but do raise concerns about standards of care and possible licensing violations; and warrant a formal CPS investigation" (Child Welfare League of America, 2003, p.29 and p. 53). There is not currently a consistent statewide protocol or approach to screening an allegation of abuse in care. Oregon needs to adopt one.</p> <p>At the outset, all reports should be presumed to be credible: "The fact that a child or other reporter has made an erroneous report in the past should not hinder a full and cautious screening of subsequent reports" (Children's Bureau, 2013, p.30).</p> <p>Standardizing screening protocols will be easier if the hotline is centralized. Some potential tools from other states that Oregon could use as examples include:</p> <ul style="list-style-type: none"> • North Carolina: Safety Assessment • Texas: Risk Assessment Tool • Washington: Structured Decision Making-Intake Decision Tree Guide • Utah: SDM Safety Assessment Tool <p>The most recent National AFCARS data shows that children and youth in substitute care in all four of these states experience less maltreatment in care than the national average, and half or less than the percentage of children and youth experiencing maltreatment in care in Oregon (National AFCARS Data, 2013 and 2012).</p> <hr/> <p>Initial Resources:</p> <p>CWLA Best Practice Guidelines: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/policy-issues/maltreatment-guidelines.pdf</p> <p>Screening Reports: https://www.childwelfare.gov/pubPDFs/repproc.pdf</p> <p>Screening Tools: All of the state tools referenced above can be found at the National Resource Center for Child Protective Services website: www.nrccps.org; Go to the Decision Making Tools Library & click on the states listed above to find the actual tool & (usually) a policy description for it.</p> <hr/> <p>Estimated Cost Level:</p> <p><input type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input checked="" type="checkbox"/> Cost neutral</p>
<p>Adopt a Standard Protocol for "Closed at Screening"</p>	<p>A critical aspect of standardizing screening protocols (see above) is establishing standard criteria for determining what circumstances must be met in order for an allegation to be "closed at screening." An evidence based standard risk assessment framework such as Structured Decision Making would support more consistent decisions and make the process less subjective.</p> <hr/> <p>Initial Resources:</p>

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
	<p>Structured Decision Making: http://www.nccdglobal.org/assessment/sdm-structured-decision-making-systems/child-welfare</p> <p>Safety Organized Practice: www.cssp.org</p> <hr/> <p>Estimated Cost Level:</p> <p><input type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input checked="" type="checkbox"/> Cost neutral</p>

4.3.2. Other Recommendations to Consider

Outside of the four priority areas discussed in the above section, Oregon may choose to consider other best practices and recommendations once the priority recommendations are addressed. These include:

- Ensure DHS has unlimited access to legal consultation representation for workers, investigators, and certifiers when making decisions regarding youth safety.** This was a recommendation from the recent Task Force on Dependency Representation. “The Oregon State Legislature should allocate funding to the Department of Human Services (DHS) to leverage federal grant and reimbursement programs to enter into a block grant (or “flat fee”) agreement with the Department of Justice (DOJ) for comprehensive agency representation in dependency cases. Additionally, the Oregon State Legislature should grant position authority to DOJ for the additional attorneys and staff required to implement this model” (Oregon Task Force on Legal Representation, 2016, p.5).

Initial Resource:

Oregon Task Force on Legal Representation:
<https://www.oregon.gov/gov/policy/Pages/LRCD.aspx>

- Ensure follow up after a report of abuse in care occurs timely and to the right individuals.** Current policy does not require DHS to notify youth or others if the report of abuse was closed at screening. If the report was not closed at screening, according to statute, DHS should be notifying attorneys, biological parents, CASAs, caseworkers and supervisors, and the Citizen Review Boards (ORS 419B.035). CWLA recommends notifying the following entities and individuals: caseworkers, foster parents, certifiers, birth/adoptive parents, child and other children in the home, law enforcement (when necessary), tribal social service workers, and the mandatory reporter (who made the initial call) of the screening decision and investigation outcome in accordance with state statutes. Current

policy does not require notification to the child or other children in the home, which is recommended in order to increase awareness of and respect for the child or youth experience in substitute care. The DHS policy should be updated to include at least the child or youth, and ensure the policy is followed.

Initial Resource:

CWLA Best Practice Guidelines:

<http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/policy-issues/maltreatment-guidelines.pdf>

- **Adopt clear protocols to ensure the information on investigations is getting to the Citizen Review Boards (CRBs) according to statute.** The review team recommends that DHS provide CPS assessment records to CRB, as required. We further recommend DHS update policy language to specifically note the requirement to inform CRBs of assessments. This simple change would increase the accountability of the investigators and DHS when abuse in care occurs.

Initial Resources:

Oregon Revised Statutes: <http://www.oregonlaws.org/ors/419B.035> at para(d)

DHS Foster Care Certification Rules:

http://www.dhs.state.or.us/policy/childwelfare/manual_1/division_200.pdf, page 71 para (c) sub para(C) sub para(v))

- **Track and report on critical incident reports and abuse reports by provider type and provider so trends can be identified before a crisis.** Reports should be built to show this data at an individual provider level and an aggregate level. For example, before a worker or team choose a provider (and before a certifier or licensor conducts an unannounced visit or investigates an allegation, or re-certifies a provider), they should consult a report showing data on the number of calls screened in and out, and number of reports founded and unfounded (and the details of those issues). Leadership at the state and branch level should have regular access to a report that shows all providers and numbers of screened out reports, screened in reports, unfounded investigations, and founded investigations by each provider. This practice would promote data driven decision making and tracking trends, rather than inconsistent responses to single incident cases.

Initial Resources: N/A, PK recommendation

4.4. Foundational Recommendations

The following recommendations are out of scope for this review, but foundational to any change efforts to address gaps in Oregon’s substitute care system. If these areas are not addressed, the other recommendations in this report will gain little or no traction. The lack of focus to date on the areas described in this section may explain why Oregon has received a number of reports and recommendations and launched various change efforts over the last ten years, but has seen little improvement to the safety of children and youth in the substitute care system.

The review team concludes that organizational culture change within DHS, using data to drive decision making and policy throughout the System, ensuring adequate staffing and reasonable caseloads for DHS staff, and focusing on recruitment and retention of quality providers must be prioritized in order to ensure that the solutions presented above bring about needed transformational change for the substitute care system.

4.4.1. Priority Recommendations

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
<p>Change the Culture of Oregon DHS Through Strong Leadership, Behavior Modeling, and Organizational Change Management</p>	<p>The culture of Oregon DHS has for some time been focused on reframing problems with the child substitute care system to deflect blame, comply with regulation, and preserve the existing System. DHS needs to refocus all of its people on prioritizing the safety of children and youth who are in the care of the state. Previous reviews, legislation, and internal change projects have all focused on various aspects of the System. It is time for DHS to see the System from the experience of the children and youth in substitute care and act from that perspective.</p> <p>Actions taken in response to this review, future breakdowns in the System, or directives from policymakers need to put the children and youth in care first and implement solutions focusing on their safety. (See next priority recommendation: <i>Focus the Whole DHS Agency and Child Welfare Workforce on Safety as the Highest Priority and Encourage any Staff Member to Speak Up with Concerns.</i>)</p> <p>The change needed at DHS is more complex than project management alone can achieve. None of the other recommendations to mend gaps in the System will successfully transform the experience of children and youth in care if the people who work at DHS do not change. DHS executives need to lead culture change and anchor it in the organization through building strong leadership skills, behavior modeling, and organizational change management.</p> <p>Behavior modeling in the workplace is an element of social learning theory that involves leading by example. People take cues from their managers, supervisors, and executives. The actions and decisions of DHS leaders and managers can have far reaching effects throughout the agency’s workforce, and can change the culture of the agency. Behavior modeling can be instituted and enhanced through leadership development activities.</p> <p>Organizational culture change requires people to change their behaviors: “organizations do not change, people do” (Prosci, 2016). In a large, bureaucratic organization like DHS, this requires winning the hearts and minds of the people</p>

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
	<p>who work for the agency – and also setting up supportive processes and strict accountability measures, and eliminating barriers to change. DHS needs move from a culture of agency protectionism to one of self evaluation and continuous improvement.</p> <p>Adopting evidence-based Organizational Change Management (OCM) processes and structures will help DHS implement the recommendations in this report and make the changes stick. DHS needs to charge its leaders with establishing a sense of urgency for culture change and assign OCM planning and implementation to a single person or group. OCM models we have used successfully in our work with public agencies are listed below.</p> <hr/> <p>Initial Resources:</p> <p>Prosci: https://www.prosci.com/change-management</p> <p>Kotter’s 8 Steps: https://www.mindtools.com/pages/article/newPPM_94.htm</p> <p>Lewin’s Change Management Model: https://www.mindtools.com/pages/article/newPPM_94.htm</p> <hr/> <p>Estimated Cost Level:</p> <p><input type="checkbox"/> Cost intensive <input checked="" type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral</p>
<p>Focus the Whole DHS Agency and Child Welfare Workforce on Safety as the Highest Priority and Encourage any Staff Member to Speak Up with Concerns</p>	<p>As part of an organizational culture change effort described above, DHS should adopt a "safety culture" as a means to increase safety for children and youth in substitute care. A "safety culture" creates organizational and cultural attributes focused on safety thus improving the psychological safety, stress recognition, and employee support necessary to effectively conduct child welfare work. The state of Tennessee has done extensive work in this area.</p> <p>"Amidst the highly salient and vivid examples of failures of the child welfare system across the country, we find that leader actions to enable a safety culture that signify safety is a leadership priority (i.e., safety climate) and that it is psychologically safe for employees to speak up about challenging situations at work can help employees cope with their extremely difficult and intensely scrutinized work and experience lower levels of emotional exhaustion. However, we also illustrate opportunities for improvement as our data reveal that many aspects of safety culture are underdeveloped (e.g., stress recognition and safety organizing). Thus, we provide provisional evidence supportive of recent calls (Commission to Eliminate Child Abuse and Neglect Fatalities, Cull et al., 2013 and Rzepnicki et al., 2010) to strengthen safety culture within a state's child welfare agencies."</p> <hr/> <p>Initial Resources:</p> <p>Michael Cull, Ph.D. (TN) Improving Child Protection with Safety Science</p> <p>Assessing Safety Culture in Child Welfare: Evidence from Tennessee: http://www.sciencedirect.com/science/article/pii/S0190740916300949</p> <hr/> <p>Estimated Cost Level:</p> <p><input type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input checked="" type="checkbox"/> Cost neutral</p>
<p>Adopt Data Driven Decision Making Processes at DHS, Focusing First on</p>	<p>Nationally there are many examples of states using data to improve outcomes for youth and families in child welfare. Oregon collects data on child maltreatment in care, but does not have a culture around using the data to drive decision-making and change. Without an increased focus and reliance upon data, the system will</p>

Recommendation	Considerations, Activities, Resources, and Estimated Cost Level
<p>the Safety in Care Outcomes that Need to Change</p>	<p>always be reactive instead of proactive.</p> <p>Oregon should take advantage of national expertise to assist with this effort, including a relatively low cost program from Chapin Hall, which includes tracking the state’s outcome measures and comparing to other member states. According to Chapin Hall, “the Data Center provides child welfare agencies with the precision tools they need to examine the extent to which they achieve their intended outcomes, whether they receive the best return on their investments, and how they might allocate future funds toward a more cost-effective system. Our suite of analytic resources enables agencies to assess performance gaps and the investments required to close them. The result is knowledge that enables states to make informed decisions about future programming and investments, sparking a cycle of continuous quality improvement based on evidence” (Chapin Hall, 2016, https://www.childwelfare.gov/pubPDFs/case). There are currently 21 state members, including Oregon’s neighbor, Washington State. Chapin Hall also provides related technical assistance.</p> <hr/> <p>Initial Resources:</p> <p>Chapin Hall: https://www.childwelfare.gov/pubPDFs/case</p> <hr/> <p>Estimated Cost Level:</p> <p><input type="checkbox"/> Cost intensive <input checked="" type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral</p>
<p>Increase Staffing Resources for CPS and Other DHS Entities</p>	<p>CWLA recommends a caseload of 12-15 children per worker for child welfare caseworkers (Sudol, 2009). Oregon does not track caseloads like other states, but the activity-based workload allocation model shows DHS workers as being able to complete only 83% of the needed work. Until the CPS workers, OLRO licensers, CPS hotline screeners, and OAAP I investigators are adequately staffed, the system will always struggle to keep on top of child and youth safety. One example provided by review participants was that visits to facilities were only required once every six months and even this is not currently being met due to staffing issues. DHS cannot adequately do what they are required to do without the staffing to comply.</p> <hr/> <p>Initial Resources:</p> <p>Using Data to Improve Systems: https://www.childwelfare.gov/topics/management/info-systems/using-data-to-improve-outcomes-for-children-youth-and-families/</p> <p>Center for State Child Welfare Data: https://www.childwelfare.gov/pubPDFs/case</p> <p>CWLA Best Practice Guidelines: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/policy</p> <p>Caseload and Work Management: https://www.childwelfare.gov/pubPDFs/case_work_management.pdf</p> <hr/> <p>Estimated Cost Level:</p> <p><input checked="" type="checkbox"/> Cost intensive <input type="checkbox"/> Low cost <input type="checkbox"/> Cost neutral</p>

4.4.2. Other Foundational Recommendations to Consider

Outside of the four priority areas discussed in the above section, Oregon may choose to consider other best practices and recommendations that will further stabilize DHS and the child substitute care system. These include:

- **DHS needs to enable a workforce culture shift and decrease staff turnover.** DHS should review best practices for improving worker recruitment and retention and adopt a strategy to increase retention by addressing some of the common barriers and issues causing workers to leave their positions. Strategies may include: increasing the quality and capacity of supervisors to train, mentor, assist, and transition caseworkers; increasing salary, opportunities for professional development, flexible schedules, supporting workers through traumatic experiences, and others. Commonly cited reasons for turnover in human services organizations – such as salaries, high caseloads, unpredictable hours, insufficient services to serve children and youth, lack of support from the Department, quality and quantity of training, negative media attention – are all occurring in Oregon right now according to review participants, so to not focus on workforce issues will ensure failure of the efforts for change (GAO, date unknown, p.3).

Initial Resources:

The NCWWI Workforce Development Framework: <http://ncwwi.org>;
http://ncwwi.org/files/Retention/1-page_summary_McFadden_et_al._2015.pdf

- **DHS should focus on recruitment and retention of quality providers.** Oregon needs to develop a statewide recruiting strategy, and assign a budget and resources to implement the strategy. There is little effort on this currently, except in rare pockets of the state, which is contributing to the scarcity of providers described in Finding I. Assessment participants recommended recruitment with both faith based and non-faith based organizations, and focusing recruitment efforts in the LGBTQ community and communities of color.

Initial Resources:

Recruitment and Retention:
http://calswec.berkeley.edu/sites/default/files/uploads/effective_practices_in_foster_parent_recruitment_and_retention.pdf

- **DHS should help build support for providers at DHS, including peer support models.**

Oregon should review models of provider support programs to implement such as: Mockingbird Model, Kinship Support Services Program, Foster Parent Mentor Program, or Fostering Hope Program.

Initial Resources:

Foster Parent Support Resources:

http://calswec.berkeley.edu/sites/default/files/uploads/effective_practices_in_foster_parent_recruitment_and_retention.pdf, http://ncwwi.org/files/Evidence_Based_and_Trauma-Informed_Practice/Best__Evidence-Based_Practices_that_Enhance_Safety.pdf

Support Groups: <http://www.fc2success.org/knowledge-center/groups-and-support/>;
<http://www.nacac.org/adoptalk/parent2parentnetwork.pdf>

Mockingbird Model: <http://mockingbirdsociety.org/index.php/what-we-do/mockingbird-family-model>,

http://calswec.berkeley.edu/sites/default/files/uploads/effective_practices_in_foster_parent_recruitment_and_retention.pdf, page 13

Kinship Support Services Program: <http://www.childsworld.ca.gov/PG2891.htm>

Foster Parent Mentor Program: <http://www.fosterforward.net/resources/foster-parent-resources/new-foster-parent-mentor-program>

Fostering Hope Program: <http://www.fosteringhopefoundation.org/>

- **Training for providers should be re-evaluated to ensure they are prepared.** Assessment participants listed skills for caring for children and youth with high needs, training on cultural competency, serving children and youth who identify as LGBTQ, and parenting skills as most important, and either too light or missing in the current training offerings. Youth in focus groups suggested training for foster parents and youth on collaborative communication and problem solving, which may reduce abuse. There are many resources and best practices on provider training models to assist Oregon when the state is ready to look at this recommendation.

Initial Resources:

Recruitment and Retention:

http://calswec.berkeley.edu/sites/default/files/uploads/effective_practices_in_foster_parent_recruitment_and_retention.pdf

5. Methodology

5.1. Three Phased Approach

The Child Safety in Substitute Care Independent Review followed a three-phased approach. Each phase is briefly described below.

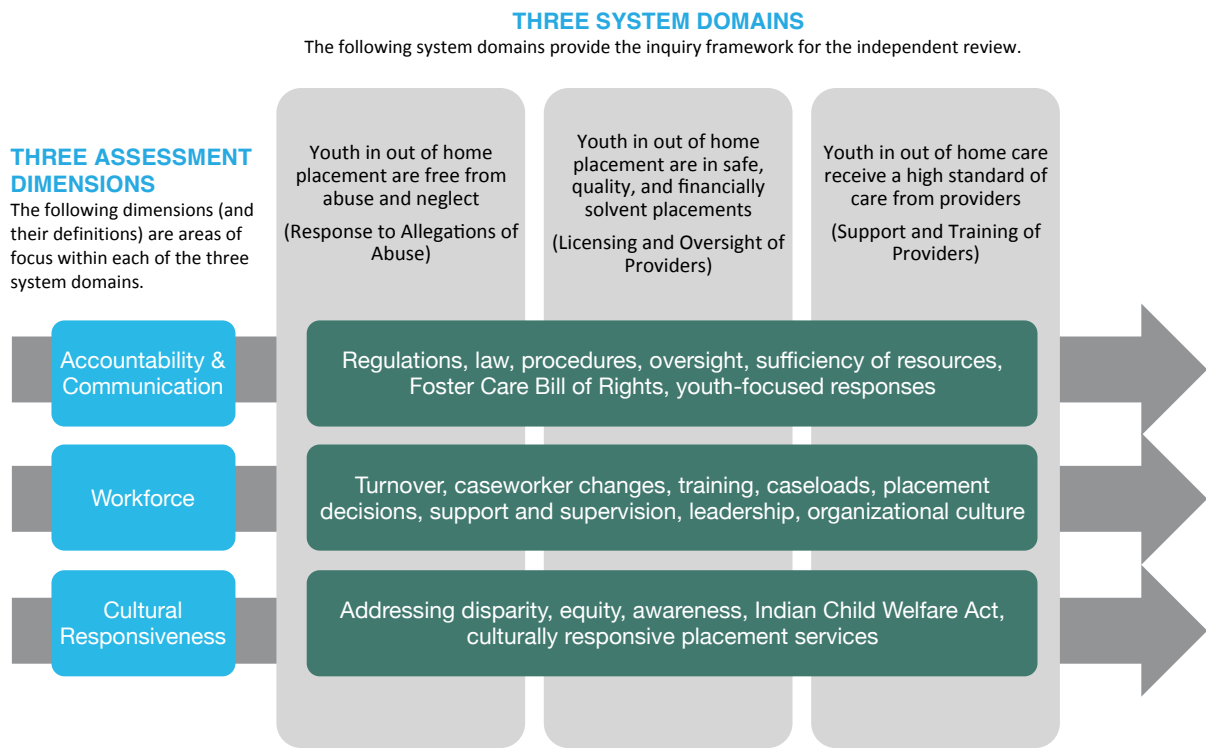
Throughout the review process, the review team focused on the perspective of the children and youth in substitute care. With each activity and each decision, we asked ourselves and the stakeholders involved: “how does this relate to safety in care?”

PHASE I – PROJECT INITIATION

The review team worked with the Governor’s Office, DHS, and the External Advisory Committee to establish project management and decision making processes. During this phase, we developed a vision and defined the scope for the review. The review team also met with Internal Resource Committee members at DHS to identify individuals, documentation, system data, and other sources that would inform the review. We developed an inquiry framework showing the major elements of the system, shown in Figure 23. The statements introducing the three system domains describe the vision for child and youth safety in each area.

Figure 23: Inquiry Framework

CHILD SAFETY IN SUBSTITUTE CARE INDEPENDENT REVIEW INQUIRY FRAMEWORK



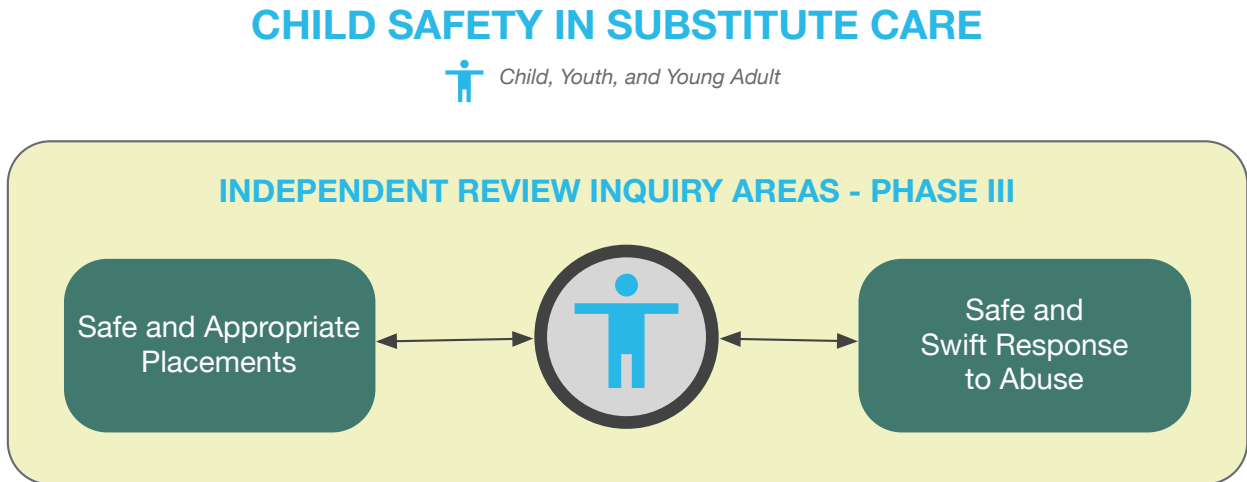
PHASE II – INITIAL ASSESSMENT

During this phase, the review team focused on gaining a broad understanding of the child substitute care system, and the major gaps and opportunities facing the System. We developed an authority inventory of the statutes, policies, and rules governing the System; using that inventory to develop regulatory system maps for each of the three system domains depicted in the inquiry framework. We reviewed over 100 reports, audits, emails, procedures, and legislation. We analyzed an initial set of System data obtained from DHS. We conducted 15 key informant interviews and two focus groups, guided by the inquiry framework above. The result of this phase was a set of 12 overall observations and 35 potential system gaps. We reviewed these results with our External Advisory Committee and the DHS Internal Resource Committee, and developed a set of criteria for selecting a set of focus areas for the Comprehensive Review phase. While we considered a number of elements during this process, the single

Key Informant Interviews are qualitative interviews with people who know what is going on within a system or community. The purpose is to collect information from a wide range of people who have first hand knowledge about the system or community in which the system operates. These experts, with their particular knowledge and understanding, can provide insight into the nature of the system problems or strengths.

most important consideration for selecting focus areas for Phase III was areas of the System that are closest to the direct experience of children and youth living in substitute care: *where they live and what happens when they experience abuse or neglect in care*. Figure 24 shows the focus areas for the Comprehensive Review. Once these areas were selected, the review team completed an Inquiry Protocol, which detailed the research questions, data sources, and participants for the Comprehensive Review.

Figure 24: Comprehensive Review Focus Areas



PHASE III – COMPREHENSIVE REVIEW

During the Comprehensive Review phase, the review team used focus groups and surveys to collect in-depth qualitative data on the two selected topics: Safe and Appropriate Placements, and Safe and Swift Response to Abuse in Care. We also analyzed quantitative data obtained from DHS, and reviewed documentation related to the topics.

The review team analyzed the data and developed nine findings. We also identified three major related barriers to improving the child substitute care system. We conducted best practice research and developed recommendations for each of our findings areas as well as a set of foundational recommendations.

See Figures 25 through 30 for details related to each of our Phase III activities.

Figure 25: Focus Groups

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research
<p>Activities & Demographics:</p> <p>Facilitated 13 focus groups and analyzed the information from the focus groups to pull overarching themes, similarities between groups, and differences between groups.</p> <ul style="list-style-type: none"> Youth, 2 focus groups held, 17 total participants Foster Parents, 3 focus groups held, 22 total participants OLRO Licensing Coordinators, 1 focus group held, 2 total participants DHS Certifiers, 1 focus group held, 12 total participants Child Care Agencies, 1 focus group held, 13 total participants Citizen Review Board Staff, 1 focus group held, 10 total participants Court Appointed Special Advocates, 1 focus group held, 9 total participants Birth Parent Mentors, 1 focus group held, 10 total participants 					
<p>Summary:</p> <p>13 Focus Groups Held, 106 Total Participants</p>					

Figure 26: Surveys

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research
<p>Activities & Demographics:</p> <p>Distributed 7 surveys and analyzed the data from the surveys to pull overarching themes, similarities between groups, and differences between groups.</p> <ul style="list-style-type: none"> Youth, snowball survey method (68 respondents) Foster Parents, snowball survey method (85 respondents) Attorneys, snowball survey method (48 respondents) Judges, snowball survey method (20 respondents) Caseworkers & Supervisors, 52% response rate (734 respondents) CPS Hotline Staff, 27% response rate (24 respondents) Child Caring Agencies, snowball survey method (13 respondents) <ul style="list-style-type: none"> ✓ 63% of attorney and judge respondents have been working in child welfare law for 10+ years ✓ Average number of years in care for youth respondents: 6.5 ✓ 37% of youth respondents were in rural placements and 31% were in non-relative foster care ✓ 33% of caseworker & supervisor respondents have been working in child welfare 10+ years ✓ 24% of foster parent respondents live in rural areas 					
<p>Summary:</p> <p>7 Surveys Distributed, 992 Total Participants</p>					

Figure 27: DHS Data

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research
<p>Activities & Demographics:</p> <p>Requested and analyzed data from DHS on identified potential gaps. Topics included:</p> <ul style="list-style-type: none"> Demographics of youth in substitute care Placement type for youth in substitute care Time in care Reports of allegations of abuse in care Demographics of youth subject to reports Provider capacity Level of need Placement stability Abuse in care allegations Resolution of abuse in care allegations Caseworker caseloads Net loss and gain of providers Allegations screened in and out 					
<p>Summary:</p> <p>Data analyzed, summarized, and included with findings</p>					

Figure 28: Documentation

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research
<p>Activities & Demographics:</p> <p>Researched, reviewed, and summarized applicable sections of reports and documentation. This included:</p> <ul style="list-style-type: none"> ▪ Child and Family Services Review Documents ▪ Task Force Reports ▪ Annual Progress Reports ▪ Committee Reports ▪ Major Litigation - past 5 years, \$50,000 + award/settlement ▪ Program Improvement Plans ▪ Recruitment & Retention Plans ▪ Various applicable reports ▪ Child Welfare Data Book ▪ Audits ▪ IV-E Program Improvement Plan ▪ Critical Incident Report ▪ Workgroup Reports ▪ Procedure Manuals ▪ Training Curriculum (applicable) ▪ Screening Protocols 					
<p>Summary:</p> <p>Researched, reviewed, and summarized applicable documentation and reports from 2002 - 2016</p>					

Figure 29: Policies & Rules

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research
<p>Activities & Demographics:</p> <p>Researched, reviewed, and inventoried state and federal regulations applicable to the assessment scope. This included:</p> <ul style="list-style-type: none"> ▪ 7 high-level graphic system maps for the three domains of the Child Substitute Care System, ▪ one-page summaries for each system map ▪ a full authority inventory (this table includes all the authorities used for the maps, and includes which domain it informs, the authority type, a quick summary, and the full citation) ✓ The maps were used to confirm assessment team knowledge of regulations ✓ The maps were used with initial assessment participants to confirm scope ✓ In the comprehensive assessment (phase III) the regulatory inventory was used to confirm knowledge of processes and procedures, and document gaps 					
<p>Summary:</p> <p>7 system maps, full regulatory inventory, and detailed gaps for areas in scope</p>					

Figure 30: Best Practices & Recommendations

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research
<p>Activities & Demographics:</p> <p>After identifying the assessment findings, the independent review team undertook an effort to identify recommendations and research best and promising practices from across the country.</p> <ul style="list-style-type: none"> ▪ Identified findings ▪ Provided recommendations ▪ Researched best and promising practices ▪ Researched regulations in other states 					
<p>Summary:</p> <p>Research and recommendations for all findings</p>					

5.2. Guiding Principles

From the beginning of the project, the independent review team used the following guiding principles to develop the findings presented in this document:

- **USE A CHILD AND YOUTH-DRIVEN PERSPECTIVE.** Be guided first and foremost by the child and youth experience. The goal of this review is to improve outcomes for the children and youth the System serves. These children and youth, along with their permanent family system and community network of support, are the primary consumers of the System’s efforts to keep children and youth safe from harm and prepared for the future. To this end, all our actions, decisions, and solutions will be shaped by how well they promote Oregon’s interest in keeping children and youth safe, stable, and nurtured while in care.
- **PRACTICE A STRENGTHS-BASED APPROACH.** Every deficiency or gap in the System is an opportunity for improvement. Strengths or positives in the System may be footholds for solutions. We believe it important to not only investigate the System for weaknesses and flaws, but to understand what is working, and identify the strengths within the System that the state needs to protect and sustain.
- **APPLY SYSTEMS THINKING TO SEE THE WHOLE PICTURE.** Multiple contributors have a part to play in improving Oregon’s substitute care system. The purpose of this review is to understand System strengths, as well as gaps in the System, including internal DHS functions and culture, collaboration with partners, and fiscal accountability for the cost of care.
- **BASE FINDINGS ON FACTS AND BE TRANSPARENT ABOUT OUR SOURCES.** Start with facts and data where possible, and corroborate with qualitative data. Participants’ qualitative experience with or perceptions of the child substitute care system is as critical as what the quantitative data shows. We will communicate how we use information provided to us.
- **BUILD BUY-IN ACROSS STAKEHOLDERS.** Early involvement of System stakeholders in the design of the assessment helps build support for the decisions, resources, and interventions that are needed to better serve children and youth in substitute care. Ensuring our independence and following these guiding principles will also ensure a high level of trust in the process and final recommendations.
- **USE A POLICY-BASED DEFINITION OF CHILD AND YOUTH SAFETY.** For the purposes of this review, child and youth safety is defined as follows:
 - **CHILD & YOUTH SAFETY IS THE STATE OF BEING FREE FROM ABUSE AND NEGLECT.** Abuse means any of the following: physical injury caused by other than accidental means; mental injury caused by cruelty including verbal harassment,

threats, and seclusion; sexual abuse or exploitation; and abandonment. Neglect is the failure to provide the care necessary to maintain physical and mental health. Abuse and neglect are defined by Oregon Statutes in the Juvenile Chapter (419B.005), and in Child Welfare Services Chapter (418.205, definition of abuse recently added by Senate Bill 1515).

5.3. Independent Review Constraints

Independent review sponsors and advisors have emphasized that this review is a first step in a long process of mending Oregon’s substitute care system. The review was given a short timeframe and charged with offering the state a few priority areas to focus on first. As expected with a review of a system of this size and complexity, the review team encountered a few challenges to our data collection activities. Those are summarized in the table below. We recommend that future efforts to collect information about the child substitute care system evaluate these constraints and identify ways to mitigate them.

Constraint	Description
<p>Incomplete or Unreliable System Data</p>	<p>Oregon currently has a disjointed data enterprise for tracking information about child and youth maltreatment in substitute care, as there are multiple agencies and programs and systems involved. Several separate data systems that do not interface and are of varying maturity levels are used across the System. There are also fields in the OR-KIDS system that would allow a richer data analysis regarding child safety that are not currently in use.</p> <p>Review participants report that the data systems are further limited by staff that do not input data accurately or in a timely manner, whether due to training, workload constraints, or other issues. We experienced this firsthand when analyzing data sets and noticing a number of “blank fields” or “unknown” data elements. This is consistent with what we have seen in data from other states’ SACWIS systems.</p> <p>Participants in this review have varying degrees of trust in the reliability of the data obtained from DHS. The review team analyzed data obtained from the ORKIDS, OLRO, and OAAPI systems to support this review. In addition to this data we also considered qualitative information gleaned from focus groups, surveys, and other means.</p> <p>See Section 3 Related Barriers for more on this topic.</p>
<p>Limited Participation from Culturally Diverse Communities</p>	<p>The review team, guided by our External Advisory Committee, made a concerted effort to include the voices and experiences of culturally diverse stakeholders within the scope of the review. During our Initial Assessment phase, we interviewed individuals who could help us understand gaps in the System from the perspective of communities that are disproportionately represented in substitute care, including tribal and non-tribal Native American groups and the urban African American community.</p> <p>Due to the limited timeframe and resources allocated to this review, we were unable to focus our qualitative data collection activities during our Comprehensive Review phase in these or other minority communities. We did not tailor questions or methodologies to the specific needs of cultural or racial minority groups, nor did we collect demographic data from focus group or survey participants. Future in depth reviews of targeted areas of the system should consider working with cultural liaisons to collect qualitative data in ways that work for minority communities.</p> <p>We believe that disproportionality and a lack of culturally relevant placements may affect</p>

Constraint	Description
	<p>safety in care, but due to the focused scope of this review, we do not make conclusions about those topics (See Section 3.4 for overall observations regarding cultural competency).</p>
<p>Nonparticipation by Some Stakeholder Groups</p>	<p>Some stakeholder groups identified in PK’s Inquiry Protocol for the Comprehensive Review phase or that were requested by members of the External Advisory Committee either chose not to, or were unable to participate in qualitative data collection activities. Those groups are listed below, with the reason for nonparticipation:</p> <ul style="list-style-type: none"> • Oregon Department of Justice (DOJ) Attorneys – We included this stakeholder group as a survey audience in our Inquiry Protocol. Due to concerns related to client-attorney privilege, the DOJ attorneys declined to participate in the survey. • Tort Attorneys – Tort attorneys that have been involved in large settlement cases against DHS for abuses of children or youth in substitute care have unique insight into the gaps and issues within the System. Because many of these attorneys are involved in current litigation with the state, we were unable to conduct a focus group with this stakeholder group. However, with assistance from our External Advisory Committee members, several tort attorneys participated in a confidential survey, and their input is included in this review. • Rural Foster Youth – We invited youth living in rural Jackson and Josephine Counties to participate in a focus group. However, due to summer schedules and other conflicts, we had to cancel this group due to low participation. We conducted two well-attended focus groups in the Portland and Salem areas. In lieu of an in-person focus group, the review team increased efforts to distribute a survey to youth statewide. A total of 68 youth responded to our survey. 18% reported living in a large city, 45% in a medium sized city, and 37% reported living in a rural or small town.
<p>Individual Case Files Not Reviewed</p>	<p>The independent review team did not review individual case files for this project. To unequivocally understand the reasons for abuse in substitute care – or the reasons why in many cases abuse has been allowed to continue - there could be some value in reviewing files from those cases where abuse was substantiated. Due to the timeframe and resources allocated for this review, combined with the priorities of the review’s External Advisory Committee, our methodology focused instead on collecting qualitative information from people involved in the System and analyzing quantitative data collected by DHS.</p>
<p>DHS Personnel Files Not Reviewed</p>	<p>The DHS Director has recently initiated an effort to analyze data from personnel files to gain a better understanding of decisions and actions taken with line workers and supervisors involved in the most serious cases of abuse in care. This information was not available during the timeframe for the independent review.</p>

6. Contributors and Sources

6.1. Contributors to the Independent Review

The Child Safety in Substitute Care Independent Review drew on the knowledge, experiences, and perceptions of hundreds of Oregonians around the state. This section lists many of those contributors, but many will remain anonymous through their participation in focus groups and surveys.

6.1.1. External Advisory Committee

- Caroline Cruz, Confederated Tribes Warm Springs
- Robin Donart, Maple Star Oregon
- Lene Garrett, CASA
- Senator Sara Gelser, Oregon State Legislator
- Josh Graves, Catholic Community Services
- Christine Hartmann, Oregon Foster Parent Association
- Mark McKechnie, Youth Rights & Justice
- Craig Opperman, Looking Glass
- Rep. Carla Piluso, Oregon State Legislator
- Katie Robertson, Foster Care Alumni , Oregon Foster Youth Connection
- Elden Rosenthal, Rosenthal Greene & Devlin, PC
- Clyde Saiki, DHS Director
- John Sciamanna, Child Welfare League of America
- Nicole Stapp, Foster Care Alumni and Advocate, Oregon Foster Youth Connection
- Rep. Duane Stark, Oregon State Legislator
- Kay Toran, Volunteers of America

- Senator Jackie Winters, Oregon State Legislator

EAC Support

- Jeannine Beatrice, DHS Chief of Staff
- Addie Smith, Governor's Office, Task Force on Dependency Representation

6.1.2. DHS Internal Resource Committee

- Abdulrahim Audi, Social Service Specialist 1 – District 2
- Stacey Ayers, Child Protective Services Program Manager –Child Welfare
- April Barrett, Human Resources Payroll Liaison – Director's Office
- Anna Cox, Data Collection & Reporting Manager – Business Intelligence Unit
- Gene Evans, Public Affairs Director – Director's Office
- Lora Edwards, Research Analyst – Office of Adult Abuse Prevention and Investigation
- Kevin George, Child Well Being Unit Co-Program Manager – Child Welfare
- Harry Gilmore, Children's Care Licensing Unit – Office of Licensing and Regulatory Oversight
- AJ Goins, Federal Policy, Planning & Resources Co-Manager – Child Welfare
- Brooke Hall, Program and Training – Office of Adult Abuse Prevention and Investigation
- Wendy Hill, District 14 District Manager – Child Welfare
- Michelle Johnson, Classification & Recruitment Manager – Human Resources
- Nadja Jones, Tribal Affairs Director – Director's Office
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- Jason Mak, Diversity & Inclusion Manager – Director’s Office
- Laurie Price, Co-Program Manager – Child Well Being Unit
- Jodi Sherwood, Project Manager – Office of the Chief Operating Officer
- Barb Southard, Developmental Disabilities Licensing Manager – Office of Licensing and Regulatory Oversight
- Julie Spencer, District 5 Program Manager – Child Welfare
- Naomi Steenson, Administrator – Governor’s Advocacy Office (former)
- Kalisha Stout, PEMC, Supervisor – District 2

6.1.3. Key Informant Interviewees (Initial Assessment Phase II)

- John Devlin, Attorney – Rosenthal Greene & Devlin, P.C.
- Group Interview: Foster Youth and Alumni – Oregon Foster Youth Connection
- Group Interview: Substitute Care Providers (CCAs) – Oregon Alliance of Children’s Programs
- John Haroldson, District Attorney – Benton County District Attorneys Office
- Tom Heidt, DHS Licensing Coordinator – DHS Central, Licensing Unit
- Therese Hutchinson, Policy, Program, & Training Manager – DHS Central, Office of Adult Abuse Prevention & Investigation
- Darin Mancuso, Foster Care Ombudsman – Governor’s Office/DHS
- Renee Moseley, Deputy Director – Bridge Meadows (community housing provider with foster care focus)
- Hon. Lindsay Partridge, Judge – Marion County Juvenile Court
- Holly Preslar, Attorney – Holly A. Preslar, Attorney at Law
- Mike and Lonnie Ribiero, Foster Parents – Harney County, OR

- Lisa Romano, Executive Director – Oregon CASA Network
- Tawna Sanchez, Interim Executive Director – NAYA Family Programs
- Kim Scott, President & CEO – Trillium Family Services
- Angela Sherbo, Supervising Attorney – Youth, Rights, & Justice
- Ruth Taylor and Parent advisor/mentor, Facilitator & Program Director – Foster Parent Advisory Committee & Morrison Child & Family Services
- Hon. Nan Waller, Presiding Judge – Multnomah County Circuit Court

6.1.4. Other Contributors

The individuals listed here provided assistance and information at the request of the independent review team or the DHS Director's Office.

- Janet Arenz, Executive Director, Oregon Alliance of Children's Programs
- James Barta, Legislative Director, Children First for Oregon
- Patricia Chamberlain, Ph.D., Science Director, Oregon Social Learning Center
- Gene Evans, Public Affairs Director, DHS
- Veronica Garcia, Executive Specialist, Oregon Alliance of Children's Programs
- Leah Hall, Program Supervisor, Morrison Child and Family Services
- Megan Hassen, Juvenile Law and Policy Counsel, Oregon Judicial Department
- Justin Hopkins, Contracts and Compliance Director, Oregon Health Authority
- Laramie Lesina, Independent Living Program Manager, Kairos
- Angela Long, Program Performance and Reporting Office Administrator, DHS
- Lisa McMahon, Program Director, Oregon Foster Youth Connection
- Amy Miller, Deputy General Counsel, Office of Public Defense Services
- Marilee Ortiz, Social Service Specialist, Child Protective Services, DHS

- Dawn Phillips, Chief of Staff, State Representative Duane Stark
- Adam Rodakowski, Assistant Program Manager, DHS
- John Thompson, Deputy Director, Office of Adult Abuse Prevention & Investigations, DHS

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